DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 9, 2022

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: October 17, 2022

Dear Administrator:

On October 5, 2022, we notified you a remedy was imposed. On November 2, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 17, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 2, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 5, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 2, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 17, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 9, 2022

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

Re: Reinspection Results
Event ID: NYFY12

Dear Administrator:

On November 2, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 2, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 5, 2022

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: August 2, 2022

Dear Administrator:

On August 12, 2022, we informed you that we may impose enforcement remedies.

On September 23, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 2, 2022

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 2, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 2, 2022.

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

payment for new admissions.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, 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 November 2, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Highland Operations Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 2, 2022. 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" and/or an "E"tag), i.e., the plan of correction should be directed to:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 February 2, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
October 5, 2022

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders
Event ID: NYFY11

Dear Administrator:

The above facility was surveyed on September 20, 2022 through September 23, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: _____ B. WING _____	C 09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND OPERATIONS LLC	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/20/22 - 9/23/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND OPERATIONS LLC	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H50284703C (MN86891/86868) however NO licensing orders were issued due to actions taken by the facility prior to survey. The following complaints were found to be SUBSTANTIATED: H50284680C (MN86871), H50284840C (MN86785), with a licensing order issued at 1805, 550, 565, 840, and 1510. The following complaint was found to be UNSUBSTANTIATED: H50284744C (MN86933) 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accurately assess a resident's bladder and bowel function on the Minimum Data Set (MDS) for 1 of 3 residents (R1) reviewed assessments. R1's indwelling catheter was not identified on the MDS. Findings include: R4's admission MDS dated 2/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring, total dependence	2 550	Corrected	10/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 550	Continued From page 3 with activities of daily living. R1 diagnosis included acute respiratory failure, sepsis, chronic kidney disease stage 4 and dependence on renal dialysis. Section H indicated R1 had an indwelling catheter. R1's quarterly MDS assessment dated 5/5/22. Section H: Bladder and Bowel did not indicate R1 had an indwelling catheter. The comprehensive nursing note dated 6/7/22, indicated R1 had no change in bladder status and had a Foley catheter. R1's quarterly MDH assessment dated 8/5/22 Section H: Bladder and Bowel did not indicate R1 had an indwelling catheter. Upon interviewed on 9/20/22, at 11:19 a.m. R1 stated he had the catheter for seven months, the entire time he had been at the facility. Upon interview on 9/20/22, at 1:59 p.m. the Director of Nursing verified the last two quarterly MDS assessments, 5/5/22 and 8/5/22 did not indicate R1 had an indwelling catheter. She acknowledged he had the indwelling catheter since his admission in February of 2022. The DON identified the probable cause was the nursing assessments, not charting accurate information in the system, and the information carried over to the MDS. The DON stated she did not complete a face-to-face observational assessment with R1. A facility policy Comprehensive Assessments and the Care Delivery Process dated 11/30/21, identified a purpose of ensuring resident assessments come from multiple sources including observation, physical assessment,	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 550	Continued From page 4 symptoms or condition-related assessments, resident and family interviews, hospital discharge summaries, consultant reports, lab and diagnosis test results and evaluations from other disciplines (dietary, respiratory social services, etc.). SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 550		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop comprehensive care plans that reflected the medical needs for 2 of 3 residents (R1 and R2) reviewed for care planned medical needs. R1's plan of care lacked interventions for catheter cares. R2's care plan lacked the use of a fitted hinge leg brace. Findings include:	2 565	Corrected	10/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 5 R1's admission Minimum Data Set (MDS) dated 2/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1 diagnosis included acute respiratory failure, sepsis, chronic kidney disease stage 4 and dependence on renal dialysis. Section H indicated R1 had an indwelling catheter. R1's care plan dated 8/15/22 did not indicate that R1 had an indwelling catheter. R1's Physician order dated 9/16/22, indicated R1 was to have routine catheter care per facility protocol. If the catheter comes out inadvertently, it should be replaced by replaced by urologist or urology PA. Upon interview on 9/20/22, at 11:19 a.m. R1 reported that the facility does not change the catheter monthly, they did change it once a while ago because there was a problem with it. "The hospital told me that is why I got the septic infection." Upon interview on 9/20/22, at 11:49 a.m. nursing assistant (NA)-A verified there was not any intervention on her daily charting for catheter care on R1. She stated she doesn't use the care plan; she is just aware when she sees a catheter on a resident, she empties it. Upon interview on 9/20/22, at 11:49 a.m. RN-A verified there was not a date for a catheter change in the orders. She questioned how the staff would when to change it if catheter care is not in the orders. She also verified there was no place to chart other cares or monitoring, including signs of infection, pain, and any urine output. She stated R1 has had the catheter the entire	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 6 time he was at the facility since February 2022, and she has done no monitoring or care with R1's catheter. She reported R1 had recently returned from the hospital following a diagnosis of urosepsis and R1 was still on levofloxacin (broad spectrum antibiotic). Upon interview on 9/20/22, at 1:59 p.m. the director or nursing (DON) reported that R1 should have a monthly scheduled catheter change in his orders and catheter monitoring. The DON verified that he did not receive catheter cares. She reported she would update his orders and care plan immediately. Upon interview on 9/20/22, at 3:01 p.m. the Administration reported he could not verify through documentation that R1 had received a catheter cares at the facility since his admission on 2/9/22. Upon interview on 9/22/22, at 10:24 the Nurse Practitioner stated the residents with indwelling catheters should be monitor per facility policy and any concerns should be reported to her. She indicated the facility should be changing his catheter. "My knowledge is they change monthly on the p.m. shift. I see that with most of my residents." R2's hospital summery dated 7/20/22, identified R2 received a fitted knee brace at the hospital prior to discharge and the facility physical therapy and occupational therapy were to follow-up with services. R2's admission nursing assessment dated 7/20/22, failed to identify the use the hinge knee brace.	2 565		

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2 565	Continued From page 7 R2 admission MDS dated 7/25/22, identified R2 had a mild cognition deficit. R2 needed extensive assistance with transferring and activities of daily living. R2 diagnosis included bilateral primary osteoarthritis of knee, pain in left knee, lymphedema (localized swelling of the body caused by abnormal accumulation of lymphatic fluid) and Type II diabetes with neuropathy R2's care plan dated 7/21/22, identified R2 to have arthritis of the knees. The interventions indicated R2 to be monitored, document and report to the provider as needed any signs of symptoms of complications related to arthritis, joint pain, joint stiffness, swelling, decline in mobility, decline in self-care ability, contracture formation/joint shape changes, crepitus (creaking or clicking with joint movement), pain after exercise or weight bearing. The plan of cares does not identify the use of a hinge knee brace. Upon observation on 9/20/22, at 3:20 p.m. R2 was lying in bed with a hospital gown and heel protectors on both legs, he was not wearing a knee brace. Upon observation on 9/21/22, at 9:11 a.m. R2 was lying in bed with a hinge knee brace on his left leg. There was an unsigned note on R2's closet door stating he was to wear leg brace at all times except when cleansing skin and to make sure brace is not put on too tightly. Upon interview on 9/21/22, at 9:11 a.m. R2 reported that he does not like to wear the brace, he stated he is not sure when he is supposed to wear and when he is not. He stated he goes for days without wearing it and then sometimes therapy will put it on.	2 565		

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2 565	Continued From page 8 Upon interview on 9/21/22, at 11:45 a.m. occupational therapist (OT)-A verified the facility did not have an order for the knee brace, however recalled he was supposed to wear it all the time per hospital. She then stated "No I think the brace was supposed to be worn when he up in his chair or attempting to ambulate. I honestly can't tell you; I've been working 10-hour days." Upon interview on 9/21/22, at 11:51 registered nurse, (RN)-A reported she was unaware that R2 had a brace, stating she had never seen a brace on him or in his room. RN-A reported working with R2 often. RN-A verified there was no documentation in the care plan or orders of the need for a knee brace. Upon interview on 9/21/22, at 12:40 p.m. the Director of Rehabilitation verified there was no order for R2's knee brace. She stated she was aware that he did have a hinge knee brace, but nursing hasn't given therapy any updated orders on him or any appointment sheets with an order. Upon interview on 9/22/22, at 10:24 a.m. the Nurse Practitioner verified that R2 received a fitted hinge knee brace at the hospital and was supposed to always wear it. She stated the only thing she has heard from the facility is that he refuses it often. Facility policy Care Area Assessments dated 11/30/21, indicated care area assessments are triggered by the MDS, then reviewed doing an in-depth, resident-specific assessment of the triggered condition, define the problem, make decision about the care plan and document interventions on the care plan. Facility policy Catheter Care Urinary; Input/Output	2 565		

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2 565	Continued From page 9 observe the residents urine level for noticeable increases or decreases. Maintain an accurate record of the residents daily output, per facility policy and procedure. Check the bag frequently to be sure he or she is not lying on the catheter and to keep the catheter tubing free of kink. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction. Or when the closed system is compromised. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 565		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence.	2 840		10/17/22

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2 840	Continued From page 10 [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure showers were offered or provided for four of four residents (R1, R2, R3, R4) who were dependent upon staff for assistance with activities of daily living (ADLs). Findings include:	2 840	Corrected	

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2 840	Continued From page 11 R1's admission Minimum Data Set (MDS) dated 2/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1 diagnosis included acute respiratory failure, sepsis, chronic kidney disease stage 4 and dependence on renal dialysis. R1's care plan dated 2/9/22, indicated R1 needed limited assistance of one staff for showers/bathing. R1's physician orders dated 4/20/22, indicated R1 needed weekly assessments and audits on shower days. Nurse to complete weekly skin check tool in Point Click Care (PCC). Upon observation on 9/20/22, at 11:19 a.m. R1 was in bed, wearing hospital gown. R1 appeared unkempt. Upon interview on 9/20/22, at 11:19 a.m. R1 reported he doesn't recall the last time he had a shower. He reported his shower day was scheduled for one of his dialysis days, but staff don't give him a shower because he is gone most of the day. Upon interview on 9/20/22, at 11:49 a.m. nursing assistant (NA)-A reported she could not recall the last time she had given R1 a shower. She reported she did not know how to find the showers in care plan. She stated she would be sure R1 receives a shower this afternoon. R2 admission MDS dated 7/25/22, identified R1 had a mild cognition deficit. R1 needed extensive assistance with transferring and activities of daily living. R2 diagnosis included bilateral primary osteoarthritis of knee, pain in left knee,	2 840		

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2 840	Continued From page 12 lymphedema (localized swelling of the body caused by abnormal accumulation of lymphatic fluid) and Type II diabetes with neuropathy R2's care plan dated 7/25/22, indicated R2 was dependent upon one staff member for showers, no days, or frequencies were assigned. Upon observation on 9/21/22, at 9:11 a.m. R2 was in bed wearing only an incontinent brief. R2 appeared unkempt. Upon interview on 9/21/22, at 9:11 a.m. R2 reported he usually does not receive showers at the facility. He reported there is one nursing assistant who will take the time and give him a shower. R1 explained that he is incontinent of stool and only gets cleaned up with wipes. R3's admission MDS dated 9/9/21, identified R3 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1's diagnosis included multiple fractures of pelvis due to a car accident. R3's care plan dated 9/9/21, indicated R1 was totally dependent on one staff to provide bath/shower. No days, times or frequencies were assigned to the shower/bath. Upon interview on 9/21/22, at 8:41 a.m. R3 reported she had not a shower since her admission to the facility on 9/8/22. Upon interview on 9/21/22, at 9:00 a.m. NA-A reported she had never given R3 a shower, she stated she was unsure how to do it with a broken pelvis and she has given R3 a washcloth, and a pan with soap and water to use to wash herself in bed.	2 840		

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2 840	Continued From page 13 R4's admission MDS dated 9/8/22, identified R4 had intact cognition. R4 needed extensive assistance with transferring and activities of daily living. R4 diagnosis included complete traumatic amputation of right food, cellulitis of lower limb, Type I Diabetes, and obesity. R4's care plan dated 9/21/22, indicated R4 was dependent on one staff for bathing/shower. No days, times or frequencies were assigned. Upon observation on 9/21/22, at 12:51 p.m. R4 was laying bed, a morbidly obese man wearing only an incontinent brief. R4 appeared unkempt. Upon interview on 9/21/22, at 12:51 p.m. R4 reported that he had not had a shower since the early part of August 2022, which included his hospital stay. He reported he had not had a shower since he was admitted to the facility on 9/8/22. He stated the staff had told him they do not have a shower room that he can physically fit in. He stated, "they just offer me sticky wipes." Upon interview on 9/21/22, at 1:17 NA-B reported that she had not given R4 a shower, stating she didn't know how and that she overheard occupational therapy in his room discussing shower methods this morning. She stated she has given him wipes and offered him assistance. In addition, she offered him a bed bath. Upon interview on 9/21/22, at 1:30 p.m. occupation therapist (OT)-A reported that R4 probably hasn't had a shower. She reported she had a conversation with R4 this morning and they will try to get him to their large shower room upstairs at the facility. She stated his blood pressure has been low and he was seen in the	2 840		

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2 840	Continued From page 14 emergency department a few nights ago. She reported he needs to be more stable with his blood pressure so we can safely shower him. The facility needs to make sure he is getting out of bed more often. Upon interview on 9/21/22, at 2:22 p.m. the Administrator reported that he could not provide any documentation of showers being given to R1, R2, R3 or R4. A facility policy, titled Activities of Daily Living (ADLs), Supporting indicated appropriate cares and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of caring including hygiene, mobility, elimination, dining, and communication. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 840		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the required services from an outside source according to part 4658.0075.	21510		10/17/22

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21510	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide rehab services as ordered for three of four residents (R1, R3, R4) reviewed for therapy services leaving the potential for decondition and declining in the health of the residents. Findings include: R1's admission Minimum Data Set (MDS) dated 2/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1 diagnosis included acute respiratory failure, sepsis, chronic kidney disease stage 4 and dependence on renal dialysis. R1's care plan dated 2/9/22, indicated R1 needed physical and occupation therapy to evaluate and treat as per physician orders. R1's physical therapy PT, recert progress report and updated therapy plan dated 9/3/22, indicated R1 needed physical therapy three to five times a week for six weeks. R1's PT note dated 9/5/22, indicated he was seen for a visit that day and not seen again until he was discharged. R1 was discharged from therapy on 9/9/22 due to hospitalization. R1's nursing assessment indicated he returned from the hospital on 9/15/22. Upon interview on 9/20/22, 11:19 a.m. R1 reported he had been back from the hospital 5 days, and no one has discussed therapy with him.	21510	Corrected	

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21510	Continued From page 16 R1 stated, "I have laid in bed since I got back, I am never going to heal and get stronger like this." R3's physician orders dated 9/2/22, indicated R3 needed occupation and physical therapy to evaluate and treat. R3's occupation therapy evaluation and plan of treatment dated 9/2/22, indicated R3 was to receive occupation therapy three to five times a week for 30 days. R3's physical therapy evaluation and plan of treatment dated 9/5/22, indicated R3 was to receive physical therapy three to five times a week for four weeks. R3's admission MDS dated 9/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1 diagnosis included multiple fractures of pelvis due to a car accident, R3's medical record lacked any physical therapy notes from 9/6/22 to 9/11/22. R3' physical therapy visit note dated 9/12/22 showed a visit was completed. Upon interview on 9/21/22, at 8:31 a.m. R3 reported she hasn't been getting as much therapy as she was told she would be getting. She reported thinking therapy was to be daily with both occupational and physical. She stated maybe she should keep track of when they come as she wasn't sure when it was. R4's admission MDS dated 9/8/22, identified R4 had intact cognition. R4 needed extensive assistance with transferring and activities of daily	21510		

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21510	Continued From page 17 living. R4 diagnosis included complete traumatic amputation of right food, cellulitis of lower limb, Type I Diabetes, and obesity. R4's physician orders dated 9/9/22, indicated R4 needed occupational and physical therapy to evaluate and treat. R4's occupation therapy evaluation and plan of treatment dated 9/9/22, indicated R4 needed occupation therapy five times a week for 90 days. R4's physical therapy evaluation and plan of treatment dated 9/17/22, indicated R4 needed physical therapy three to five times a week for 30 days. Upon interview on 9/21/22, at 12:51 p.m. R4 reported he had to beg for therapy at the facility. Stating he threatened to get an attorney as he had been in the facility for nine days and physical therapy had not met with him. He stated he is fearful that the facility was negligent in his cares, and he will be suffering either medically or financially. "Physical therapy did not evaluate me for 9 days following admission; therefore, I am lying in bed declining." Upon interview on 9/22/22, at 10:24 a.m. the Nurse Practitioner reported she has heard complaints from multiple residents about not receiving their rehab services. She stated she was going to be bring this up at an IDT meeting, but they have not had any. She reported she had not heard from therapy that they were missing visits, not admitting residents within 48 hours, or changing schedules. Upon interview on 9/22/22, at 3:29 p.m. the Director of Rehabilitation Services reported the	21510		

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21510	Continued From page 18 rehabilitation department has a staffing shortage. She reported she was aware that R1 returned from the hospital and since he is in the Transitional Care Unit, he has standing orders to restart therapy following a hospital stay. She reported R1 probably would not be evaluated for occupation therapy until 9/23/22 and physical therapy 9/28/22. She was aware that R3 and R4 had delayed evaluations with physical therapy and again because of staffing. She stated therapy performs services up to four times per week. She verified that R1, R3 and R4 had orders for three to five times a week and stated that was an error. She reported that therapy can change orders on residents at any time. They can change the certification and that populates an order to the physician. Upon interview on 9/23/22, at 12:30 p.m. the director of nursing (DON) reported her expectation is for rehab services to evaluate the resident as soon as possible within 48 hours or less. She stated that for most of the residents on the TCU the main reason is for rehabilitation services. She was unaware of residents missing therapy or not being evaluated soon following admission. Upon interview on 9/23/22, at 1:01 p.m. the Administrator reported his expectation is for all disciplines of therapy to evaluate and start treatments as so as possible within 24 to 48 hours. The facility Management Services Agreement with the therapy agency (manager) dated, 9/2/22, the therapy agency/manager shall be free to choose both how and when to perform the services subject to completion deadlines established by the company/facility (Highland	21510		

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21510	Continued From page 19 Operations). The manager will maintain compliance training and auditing. A specific rehabilitation services policy was requested however none received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21510		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the dignity of 3 of 3 residents (R1, R7, and R6) were evaluated for indwelling catheter cares. R1, R6 and R7 were not provided a leg bag for daytime use or provided a cover for the night bag in communal areas of the facility. Finding include: R1's admission Minimum Data Set (MDS) dated	21805	Corrected	10/17/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00494	A. BUILDING: _____ B. WING _____	C 09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND OPERATIONS LLC	2319 WEST SEVENTH STREET SAINT PAUL, MN 55116

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21805	Continued From page 20 2/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1 diagnosis included acute respiratory failure, sepsis, chronic kidney disease stage 4 and dependence on renal dialysis. R1 had an indwelling Foley catheter. Upon interview on 9/20/22, at 11:19 a.m. R1 reported asking daily for a catheter leg bag from the facility but was told they do not have catheter leg bags. R1 stated the facility sends him to dialysis with an uncovered night bag attached underneath his wheelchair. R7's quarterly MDS dated 6/21/22, identified R had a mild cognitive deficit. R7 needed total dependence for transfers and extensive assistance with activities of daily living. R7 diagnosis included cerebral infarction and epilepsy. R7 had an indwelling Foley catheter. Upon observation on 9/20/22, at 12:50 p.m. R7 was seated in his wheelchair in the commons area with his catheter night bag attached below his wheelchair with the urine visible. Upon interview on 9/20/22, at 12:50 p.m. R7 stated he would like a leg bag, but he wears whatever the staff put on him. He stated he has never asked for a leg bag but has asked for his bag to covered and staff does not cover the bag. Upon interview on 9/20/22, at 2:22 p.m. nursing assistant (NA)-B reported the facility does not have leg bags, stating "there is some kind of shortage". He acknowledged two residents he cares for have asked for them. He reported he had never seen anything to cover catheter bags at the facility. R6's admission MDS dated 9/15/22, identified R6	21805		

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21805	Continued From page 21 had intact cognition. R6 needed extensive assistance with transferring and activities of daily living. R6 diagnosis included pneumonia, sepsis, unspecified, and heart failure. R6 had an indwelling Foley catheter. Upon observation on 9/22/22, at 3:54 p.m. the surveyor heard a resident yelling in the hallway "can someone help me, I don't want to run this damn thing over." R6 was dragging his catheter night bag under his wheelchair with no cover. TMA-A assisted R6 in the hallway by wrapping the catheter bag up in a pillowcase and re-attaching the bag underneath his wheelchair. Upon interview on 9/22/22, at 3:57 p.m. R6 stated that he drags the catheter around every day and the staff keep telling him they are out of leg bags. He reported he always wore a leg bag at home. He stated he does not really care if the urine is showing but fears an infection with the bag falling to the floor all the time. Upon observation on 9/22/22, at 4:09 p.m. R6 was seated in the hallway again and the catheter the TMA had wrapped in a pillowcase had fallen to the floor. R6 was again shouting for assistance. NA-B took R6 back to his bedroom. Upon observation on 9/22/22, at 4:25 p.m. R6 was rolling down the hall in his wheelchair with the catheter night bag full under his chair uncovered. He was stating in the hallways "Damn it, I am not going back to my room, I'll just run it over." Upon interview on 9/22/22, at 4:27 p.m. registered nurse (RN)-B stated NA-B had gone upstairs in the facility to locate a leg bag for R6. She reported there were none on the first floor,	21805		

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21805	Continued From page 22 and she was not aware that NA-B had not emptied R6's bag before leaving R6. Upon interview 9/23/22 at 12:30 p.m. the director of nursing (DON) stated the facility does have leg bags and covers. She reported a while back the facility had trouble getting leg bag extenders due to a supply shortage, but not currently to her knowledge. She stated all residents with catheter should have a leg bag on during the day and changed into the night bag at night. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21805		

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	245028	A. BUILDING _____ B. WING _____	C 09/23/2022

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F 000	INITIAL COMMENTS On 9/20/22 - 9/23/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H50284703C (MN86891/86868) however NO licensing orders were issued due to actions taken by the facility prior to survey. The following complaints were found to be SUBSTANTIATED: H50284680C (MN86871), H50284840C (MN86785), with a licensing order issued at F550, F641, F656, F677, F825 The following complaint was found to be UNSUBSTANTIATED: H50284744C (MN86933) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		10/17/22

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

Electronically Signed | 10/15/2022

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

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F 550	Continued From page 1 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	F 550		

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F 550	Continued From page 2 subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the dignity of 3 of 3 residents (R1, R7, and R6) were evaluated for indwelling catheter cares. R1, R6 and R7 were not provided a leg bag for daytime use or provided a cover for the night bag in communal areas of the facility. Finding include: R1's admission Minimum Data Set (MDS) dated 2/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1 diagnosis included acute respiratory failure, sepsis, chronic kidney disease stage 4 and dependence on renal dialysis. R1 had an indwelling Foley catheter. Upon interview on 9/20/22, at 11:19 a.m. R1 reported asking daily for a catheter leg bag from the facility but was told they do not have catheter leg bags. R1 stated the facility sends him to dialysis with an uncovered night bag attached underneath his wheelchair. R7's quarterly MDS dated 6/21/22, identified R had a mild cognitive deficit. R7 needed total dependence for transfers and extensive assistance with activities of daily living. R7 diagnosis included cerebral infarction and epilepsy. R7 had an indwelling Foley catheter. Upon observation on 9/20/22, at 12:50 p.m. R7 was seated in his wheelchair in the commons area with his catheter night bag attached below his wheelchair with the urine visible. Upon	F 550	R 1 was given a leg bag on 9/22/22. R 1 indwelling foley catheter orders and were reviewed and updated to include change leg bag at night to drainage bag. Catheter care was added to the resident task tab. R 7 was given a leg bag on 9/22/22. R 7 indwelling foley catheter orders and were reviewed and updated to include change leg bag at night to drainage bag. Catheter care was added to the resident task tab. R 6 was given a leg bag on 9/22/22. R 6 indwelling foley catheter orders and were reviewed and updated to include change leg bag at night to drainage bag. Catheter care was added to the resident task tab. All other residents who receive catheter care, their orders, task tab and care plan were reviewed and updated as needed. Future residents, their catheter care orders, care plan and task tab will be implemented. The nursing staff will also be in-serviced on where resident supplies are kept and supplies will be delivered to the units as needed. Nursing staff was in-serviced on the urinary leg bag policy with emphasis on item #3 that a new sterile leg bags should be given every time the leg bag is used. In addition, the nursing staff was in-serviced on Urinary/Catheter care policy with focus on infection control item #2b that the urinary drainage bags should not drag on the floor. Director of Nursing and/or designee is responsible for compliance. Audits on leg bag for daytime use	

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F 550	Continued From page 3 interview on 9/20/22, at 12:50 p.m. R7 stated he would like a leg bag, but he wears whatever the staff put on him. He stated he has never asked for a leg bag but has asked for his bag to covered and staff does not cover the bag. Upon interview on 9/20/22, at 2:22 p.m. nursing assistant (NA)-B reported the facility does not have leg bags, stating "there is some kind of shortage". He acknowledged two residents he cares for have asked for them. He reported he had never seen anything to cover catheter bags at the facility. R6's admission MDS dated 9/15/22, identified R6 had intact cognition. R6 needed extensive assistance with transferring and activities of daily living. R6 diagnosis included pneumonia, sepsis, unspecified, and heart failure. R6 had an indwelling Foley catheter. Upon observation on 9/22/22, at 3:54 p.m. the surveyor heard a resident yelling in the hallway "can someone help me, I don't want to run this damn thing over." R6 was dragging his catheter night bag under his wheelchair with no cover. TMA-A assisted R6 in the hallway by wrapping the catheter bag up in a pillowcase and re-attaching the bag underneath his wheelchair. Upon interview on 9/22/22, at 3:57 p.m. R6 stated that he drags the catheter around every day and the staff keep telling him they are out of leg bags. He reported he always wore a leg bag at home. He stated he does not really care if the urine is showing but fears an infection with the bag falling to the floor all the time. Upon observation on 9/22/22, at 4:09 p.m. R6	F 550	requests will be audited 2x week for 2 weeks then weekly x 2 weeks, then monthly x 2 months to ensure sustained compliance. Audit results will be reviewed by the Administrator and then taken to QAPI for review and recommendation. Compliance: October 17, 2022	

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F 550	Continued From page 4 was seated in the hallway again and the catheter the TMA had wrapped in a pillowcase had fallen to the floor. R6 was again shouting for assistance. NA-B took R6 back to his bedroom. Upon observation on 9/22/22, at 4:25 p.m. R6 was rolling down the hall in his wheelchair with the catheter night bag full under his chair uncovered. He was stating in the hallways "Damn it, I am not going back to my room, I'll just run it over." Upon interview on 9/22/22, at 4:27 p.m. registered nurse (RN)-B stated NA-B had gone upstairs in the facility to locate a leg bag for R6. She reported there were none on the first floor, and she was not aware that NA-B had not emptied R6's bag before leaving R6. Upon interview 9/23/22 at 12:30 p.m. the director of nursing (DON) stated the facility does have leg bags and covers. She reported a while back the facility had trouble getting leg bag extenders due to a supply shortage, but not currently to her knowledge. She stated all residents with catheter should have a leg bag on during the day and changed into the night bag at night. A facility policy Catheter Care, Urinary dated 11/1/21, indicated catheter tubing and drainage bags are to be kept off the floor.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		10/17/22

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F 641	Continued From page 5 by: Based on interview and document review, the facility failed to accurately assess a resident's bladder and bowel function on the Minimum Data Set (MDS) for 1 of 3 residents (R1) reviewed assessments. R1's indwelling catheter was not identified on the MDS. Findings include: R4's admission MDS dated 2/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring, total dependence with activities of daily living. R1 diagnosis included acute respiratory failure, sepsis, chronic kidney disease stage 4 and dependence on renal dialysis. Section H indicated R1 had an indwelling catheter. R1's quarterly MDS assessment dated 5/5/22. Section H: Bladder and Bowel did not indicate R1 had an indwelling catheter. The comprehensive nursing note dated 6/7/22, indicated R1 had no change in bladder status and had a Foley catheter. R1's quarterly MDH assessment dated 8/5/22 Section H: Bladder and Bowel did not indicate R1 had an indwelling catheter. Upon interviewed on 9/20/22, at 11:19 a.m. R1 stated he had the catheter for seven months, the entire time he had been at the facility. Upon interview on 9/20/22, at 1:59 p.m. the Director of Nursing verified the last two quarterly MDS assessments, 5/5/22 and 8/5/22 did not indicate R1 had an indwelling catheter. She	F 641	R 1 MDS dated 8/5/22 was modified on 9/20/22 to include use of indwelling catheter. All other residents who have indwelling catheter□s MDSs were review for accuracy for indwelling catheter use and was modified as needed. Future residents with indwelling catheters will be accurately identified on the MDS assessment. The MDS coordinator will be in-serviced on the Resident Assessment Policy with emphasis on completing the quarterly assessment that includes assessment of the urinary function and item #11 that the person signing the section attest to the accuracy of the information contained. Director of Nursing and/or designee is responsible for compliance. Audits on resident quarterly assessment completion for coding accuracy for resident urinary function will begin 2x week for 2 weeks then weekly x 2 weeks, then monthly x 2 months to ensure sustained compliance. Audit results will be reviewed by the Administrator and then taken to QAPI for review and recommendation. Compliance: October 17, 2022	

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F 641	Continued From page 6 acknowledged he had the indwelling catheter since his admission in February of 2022. The DON identified the probable cause was the nursing assessments, not charting accurate information in the system, and the information carried over to the MDS. The DON stated she did not complete a face-to-face observational assessment with R1. A facility policy Comprehensive Assessments and the Care Delivery Process dated 11/30/21, identified a purpose of ensuring resident assessments come from multiple sources including observation, physical assessment, symptoms or condition-related assessments, resident and family interviews, hospital discharge summaries, consultant reports, lab and diagnosis test results and evaluations from other disciplines (dietary, respiratory social services, etc.).	F 641		
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.	F 655		10/17/22

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F 655	Continued From page 7 (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). §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 develop a person-centered baseline care plan within 48 hours of admission for 1 of 3 (R4) residents reviewed for care plans. R4 did not have a care plan in place for 12 days that included the information necessary to properly care for R4. R4's admission MDS dated 9/8/22, identified R4 had intact cognition. R4 needed extensive assistance with transferring and activities of daily	F 655	R 4 care plan was initiated on 9/15/22 and updated on 9/21/22. All other new admissions from survey exit until present were reviewed and care plans were initiated as needed. New residents will have their baseline care plan initiated per policy. Nursing staff were in-serviced on Care Plan (Baseline) policy that indicates the resident care plan must be initiated 48 hours after admission to the facility and	

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F 655	Continued From page 8 living. R4 diagnosis included complete traumatic amputation of right food, cellulitis of lower limb, Type I Diabetes, and morbid obesity. R4's care plan dated 9/19/22, indicated focus, goals, and interventions by the dietary department. Interventions included obtain weight per facility policy. Provide, serve diet as ordered. The care plan lacked nursing, social services and life enrichment focus, goals, and interventions. Upon interview on 9/21/22, at 1:17 p.m. nursing assistant (NA)-C stated the care plan consisted only dietary interventions. NA-C stated she did not know to shower R4 since he was morbidly obese, so she offered him wipes for cleansing. She reported she thought he was a Hoyer lift because there was a mechanical lift left in his room; however, NA-C denied using the lift to transfer R4. Upon interview on 9/21/22, at 3:07 p.m. licensed practical nurse (LPN)-A stated he was the nurse who did the admission on R4. He reported and verified that he had done the initial nursing assessment on 9/8/22. He stated once the assessment is completed the next step is to click on "care plan" and the assessment populates and creates the person-centered plan of care. LPN-A stated in Ppoint of Care (facility software program) that the care plan had not auto populated on 9/8/22. He stated he did not verify if the care plan was in place after completing the admission assessment on 9/8/22. Upon interview on 9/21/22, at 3:29 p.m. the director of nursing, (DON) stated R6 did not have a complete care plan within 48 hours of admission. She stated the admitting nurse	F 655	the nursing team was educated on the process on how to initiate the electronic version of the resident care plan upon admission. Director of Nursing and/or designee is responsible for compliance. Audits on initiation of the resident care plan upon admission will begin 2x week for 2 weeks then weekly x 2 weeks, then monthly x 2 months to ensure sustained compliance. Audit results will be reviewed by the Administrator and then taken to QAPI for review and recommendation. Compliance: October 17, 2022	

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F 655	Continued From page 9 follows the admission assessments in point of care that triggers the care plan. The admitting nurse or the next nurse should have identified the care plan was not complete stating "This does need a cross check." A facility policy, Admission Assessment and Follow-up: Role of the Nurse indicated the purpose of the procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the residents, initiating the care plan, and completing required assessment instruments, including the MDS.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		10/17/22

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F 656	Continued From page 10 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop comprehensive care plans that reflected the medical needs for 2 of 3 residents (R1 and R2) reviewed for care planned medical needs. R1's plan of care lacked interventions for catheter cares. R2's care plan lacked the use of a fitted hinge leg brace. Findings include: R1's admission Minimum Data Set (MDS) dated 2/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1 diagnosis included acute respiratory failure, sepsis, chronic kidney disease stage 4 and dependence on renal	F 656	R 1 and R 2 comprehensive care plan was reviewed and updated to include use of urinary drainage systems on 9/22/22. R 2 care plan was updated to include use of hinged brace. All other residents from survey exit until present will have their comprehensive care plans reviewed and updated as needed. Future residents will have a comprehensive care plan initiated per facility care plan policy. The IDT team will be in-serviced on the Comprehensive Care Plan policy item#11 that the comprehensive care plan is developed within 7 days of the completion of the MDS and all care areas will be identified in the resident care plan. Director of Nursing and/or designee is	

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F 656	Continued From page 11 dialysis. Section H indicated R1 had an indwelling catheter. R1's care plan dated 8/15/22 did not indicate that R1 had an indwelling catheter. R1's Physician order dated 9/16/22, indicated R1 was to have routine catheter care per facility protocol. If the catheter comes out inadvertently, it should be replaced by replaced by urologist or urology PA. Upon interview on 9/20/22, at 11:19 a.m. R1 reported that the facility does not change the catheter monthly, they did change it once a while ago because there was a problem with it. "The hospital told me that is why I got the septic infection." Upon interview on 9/20/22, at 11:49 a.m. nursing assistant (NA)-A verified there was not any intervention on her daily charting for catheter care on R1. She stated she doesn't use the care plan; she is just aware when she sees a catheter on a resident, she empties it. Upon interview on 9/20/22, at 11:49 a.m. RN-A verified there was not a date for a catheter change in the orders. She questioned how the staff would when to change it if catheter care is not in the orders. She also verified there was no place to chart other cares or monitoring, including signs of infection, pain, and any urine output. She stated R1 has had the catheter the entire time he was at the facility since February 2022, and she has done no monitoring or care with R1's catheter. She reported R1 had recently returned from the hospital following a diagnosis of urosepsis and R1 was still on levofloxacin (broad	F 656	responsible for compliance. Audits on completion of the comprehensive care plan will begin 2x week for 2 weeks then weekly x 2 weeks, then monthly x 2 months to ensure sustained compliance. Audit results will be reviewed by the Administrator and then taken to QAPI for review and recommendation. Compliance: October 17, 2022	

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F 656	Continued From page 12 spectrum antibiotic). Upon interview on 9/20/22, at 1:59 p.m. the director or nursing (DON) reported that R1 should have a monthly scheduled catheter change in his orders and catheter monitoring. The DON verified that he did not receive catheter cares. She reported she would update his orders and care plan immediately. Upon interview on 9/20/22, at 3:01 p.m. the Administration reported he could not verify through documentation that R1 had received a catheter cares at the facility since his admission on 2/9/22. Upon interview on 9/22/22, at 10:24 the Nurse Practitioner stated the residents with indwelling catheters should be monitor per facility policy and any concerns should be reported to her. She indicated the facility should be changing his catheter. "My knowledge is they change monthly on the p.m. shift. I see that with most of my residents." R2's hospital summery dated 7/20/22, identified R2 received a fitted knee brace at the hospital prior to discharge and the facility physical therapy and occupational therapy were to follow-up with services. R2's admission nursing assessment dated 7/20/22, failed to identify the use the hinge knee brace. R2 admission MDS dated 7/25/22, identified R2 had a mild cognition deficit. R2 needed extensive assistance with transferring and activities of daily living. R2 diagnosis included bilateral primary	F 656		

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F 656	Continued From page 13 osteoarthritis of knee, pain in left knee, lymphedema (localized swelling of the body caused by abnormal accumulation of lymphatic fluid) and Type II diabetes with neuropathy R2's care plan dated 7/21/22, identified R2 to have arthritis of the knees. The interventions indicated R2 to be monitored, document and report to the provider as needed any signs of symptoms of complications related to arthritis, joint pain, joint stiffness, swelling, decline in mobility, decline in self-care ability, contracture formation/joint shape changes, crepitus (creaking or clicking with joint movement), pain after exercise or weight bearing. The plan of cares does not identify the use of a hinge knee brace. Upon observation on 9/20/22, at 3:20 p.m. R2 was lying in bed with a hospital gown and heel protectors on both legs, he was not wearing a knee brace. Upon observation on 9/21/22, at 9:11 a.m. R2 was lying in bed with a hinge knee brace on his left leg. There was an unsigned note on R2's closet door stating he was to wear leg brace at all times except when cleansing skin and to make sure brace is not put on too tightly. Upon interview on 9/21/22, at 9:11 a.m. R2 reported that he does not like to wear the brace, he stated he is not sure when he is supposed to wear and when he is not. He stated he goes for days without wearing it and then sometimes therapy will put it on. Upon interview on 9/21/22, at 11:45 a.m. occupational therapist (OT)-A verified the facility did not have an order for the knee brace,	F 656		

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F 656	Continued From page 14 however recalled he was supposed to wear it all the time per hospital. She then stated "No I think the brace was supposed to be worn when he up in his chair or attempting to ambulate. I honestly can't tell you; I've been working 10-hour days." Upon interview on 9/21/22, at 11:51 registered nurse, (RN)-A reported she was unaware that R2 had a brace, stating she had never seen a brace on him or in his room. RN-A reported working with R2 often. RN-A verified there was no documentation in the care plan or orders of the need for a knee brace. Upon interview on 9/21/22, at 12:40 p.m. the Director of Rehabilitation verified there was no order for R2's knee brace. She stated she was aware that he did have a hinge knee brace, but nursing hasn't given therapy any updated orders on him or any appointment sheets with an order. Upon interview on 9/22/22, at 10:24 a.m. the Nurse Practitioner verified that R2 received a fitted hinge knee brace at the hospital and was supposed to always wear it. She stated the only thing she has heard from the facility is that he refuses it often. Facility policy Care Area Assessments dated 11/30/21, indicated care area assessments are triggered by the MDS, then reviewed doing an in-depth, resident-specific assessment of the triggered condition, define the problem, make decision about the care plan and document interventions on the care plan. Facility policy Catheter Care Urinary; Input/Output observe the residents urine level for noticeable increases or decreases. Maintain an accurate	F 656		

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F 656	Continued From page 15 record of the residents daily output, per facility policy and procedure. Check the bag frequently to be sure he or she is not lying on the catheter and to keep the catheter tubing free of kink. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction. Or when the closed system is compromised.	F 656		
F 677 SS=E	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 ensure showers were offered or provided for four of four residents (R1, R2, R3, R4) who were dependent upon staff for assistance with activities of daily living (ADLs). Findings include: R1's admission Minimum Data Set (MDS) dated 2/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1 diagnosis included acute respiratory failure, sepsis, chronic kidney disease stage 4 and dependence on renal dialysis. R1's care plan dated 2/9/22, indicated R1 needed limited assistance of one staff for showers/bathing.	F 677	R 1 received showers on 9/21/22. R 1's shower preferences were entered into the task tab and care plan. R 2 received a shower and person cares on 9/22/22 and clothing was obtained for him. R 2's care plan and task tab were updated with resident shower preferences. R 3 was showered on 9/22/22. R 3's care plan and task tab was updated with resident preferences. R 4 was given a bed bath on 10/6/2022 and the resident care plan was updated to include bed baths until resident is able to tolerate sitting up in the wheelchair. For R 1, R 2, R 3 and R4 skin checks were conducted, and any skin alterations were documented. All other residents shower preferences and schedule was reviewed, and care plans/task tabs updated as needed.	10/17/22

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F 677	Continued From page 16 R1's physician orders dated 4/20/22, indicated R1 needed weekly assessments and audits on shower days. Nurse to complete weekly skin check tool in Point Click Care (PCC). Upon observation on 9/20/22, at 11:19 a.m. R1 was in bed, wearing hospital gown. R1 appeared unkempt. Upon interview on 9/20/22, at 11:19 a.m. R1 reported he doesn't recall the last time he had a shower. He reported his shower day was scheduled for one of his dialysis days, but staff don't give him a shower because he is gone most of the day. Upon interview on 9/20/22, at 11:49 a.m. nursing assistant (NA)-A reported she could not recall the last time she had given R1 a shower. She reported she did not know how to find the showers in care plan. She stated she would be sure R1 receives a shower this afternoon. R2 admission MDS dated 7/25/22, identified R1 had a mild cognition deficit. R1 needed extensive assistance with transferring and activities of daily living. R2 diagnosis included bilateral primary osteoarthritis of knee, pain in left knee, lymphedema (localized swelling of the body caused by abnormal accumulation of lymphatic fluid) and Type II diabetes with neuropathy R2's care plan dated 7/25/22, indicated R2 was dependent upon one staff member for showers, no days, or frequencies were assigned. Upon observation on 9/21/22, at 9:11 a.m. R2 was in bed wearing only an incontinent brief. R2	F 677	Future residents will have preferences established during the admission process and resident refusals will be documented. Nursing staff was in-serviced on the ADL Support Policy with focus on item #2 that services will be provided to residents who require assistance and is a part of the plan of care for that resident. Director of Nursing and/or designee is responsible for compliance. Audits on resident shower acceptance and refusals will begin 2x week for 2 weeks then weekly x 2 weeks, then monthly x 2 months to ensure sustained compliance. Audit results will be reviewed by the Administrator and then taken to QAPI for review and recommendation. Compliance: October 17, 2022	

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F 677	Continued From page 17 appeared unkempt. Upon interview on 9/21/22, at 9:11 a.m. R2 reported he usually does not receive showers at the facility. He reported there is one nursing assistant who will take the time and give him a shower. R1 explained that he is incontinent of stool and only gets cleaned up with wipes. R3's admission MDS dated 9/9/21, identified R3 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1's diagnosis included multiple fractures of pelvis due to a car accident. R3's care plan dated 9/9/21, indicated R1 was totally dependent on one staff to provide bath/shower. No days, times or frequencies were assigned to the shower/bath. Upon interview on 9/21/22, at 8:41 a.m. R3 reported she had not a shower since her admission to the facility on 9/8/22. Upon interview on 9/21/22, at 9:00 a.m. NA-A reported she had never given R3 a shower, she stated she was unsure how to do it with a broken pelvis and she has given R3 a washcloth, and a pan with soap and water to use to wash herself in bed. R4's admission MDS dated 9/8/22, identified R4 had intact cognition. R4 needed extensive assistance with transferring and activities of daily living. R4 diagnosis included complete traumatic amputation of right food, cellulitis of lower limb, Type I Diabetes, and obesity. R4's care plan dated 9/21/22, indicated R4 was	F 677		

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F 677	Continued From page 18 dependent on one staff for bathing/shower. No days, times or frequencies were assigned. Upon observation on 9/21/22, at 12:51 p.m. R4 was laying bed, a morbidly obese man wearing only an incontinent brief. R4 appeared unkempt. Upon interview on 9/21/22, at 12:51 p.m. R4 reported that he had not had a shower since the early part of August 2022, which included his hospital stay. He reported he had not had a shower since he was admitted to the facility on 9/8/22. He stated the staff had told him they do not have a shower room that he can physically fit in. He stated, "they just offer me sticky wipes." Upon interview on 9/21/22, at 1:17 NA-B reported that she had not given R4 a shower, stating she didn't know how and that she overheard occupational therapy in his room discussing shower methods this morning. She stated she has given him wipes and offered him assistance. In addition, she offered him a bed bath. Upon interview on 9/21/22, at 1:30 p.m. occupation therapist (OT)-A reported that R4 probably hasn't had a shower. She reported she had a conversation with R4 this morning and they will try to get him to their large shower room upstairs at the facility. She stated his blood pressure has been low and he was seen in the emergency department a few nights ago. She reported he needs to be more stable with his blood pressure so we can safely shower him. The facility needs to make sure he is getting out of bed more often. Upon interview on 9/21/22, at 2:22 p.m. the Administrator reported that he could not provide	F 677		

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F 677	Continued From page 19 any documentation of showers being given to R1, R2, R3 or R4. A facility policy, titled Activities of Daily Living (ADLs), Supporting indicated appropriate cares and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of caring including hygiene, mobility, elimination, dining, and communication.	F 677		
F 825 SS=E	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide rehab services as ordered for three of four residents (R1, R3, R4) reviewed for	F 825	R 1 was seen by Physical Therapy beginning 9/30/22 and Occupational Therapy beginning 9/23/22. R1 continues	10/17/22

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F 825	Continued From page 20 therapy services leaving the potential for decondition and declining in the health of the residents. Findings include: R1's admission Minimum Data Set (MDS) dated 2/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1 diagnosis included acute respiratory failure, sepsis, chronic kidney disease stage 4 and dependence on renal dialysis. R1's care plan dated 2/9/22, indicated R1 needed physical and occupation therapy to evaluate and treat as per physician orders. R1's physical therapy PT, recert progress report and updated therapy plan dated 9/3/22, indicated R1 needed physical therapy three to five times a week for six weeks. R1's PT note dated 9/5/22, indicated he was seen for a visit that day and not seen again until he was discharged. R1 was discharged from therapy on 9/9/22 due to hospitalization. R1's nursing assessment indicated he returned from the hospital on 9/15/22. Upon interview on 9/20/22, 11:19 a.m. R1 reported he had been back from the hospital 5 days, and no one has discussed therapy with him. R1 stated, "I have laid in bed since I got back, I am never going to heal and get stronger like this." R3's physician orders dated 9/2/22, indicated R3 needed occupation and physical therapy to	F 825	to be seen by occupational therapy 3 to 5 times weekly and Physical Therapy 5 times weekly. R 3 was seen by Physical Therapy beginning 9/5/22 and Occupational Therapy 9/2/22. R3 continues to be seen by physical therapy 3 to 5 times weekly and occupational therapy 3 to 5 times weekly R 4 was seen by Physical Therapy beginning 9/17/22 and Occupational Therapy beginning 9/9/22. R4 continues to be seen by physical therapy 3 to 5 times weekly and occupational therapy 5 times weekly. For R 1, R 3 and R 4 the MD was made aware of the delay in therapy services. The MD response will be recorded in the resident electronic medical record. A new physical therapist was hired on October 6, 2022. Current and future residents who require therapy services will be seen per facility policy. Director of Therapy and/or designee is responsible for compliance. Audits on timeliness of therapy start of care will begin 2x week for 2 weeks then weekly x 2 weeks, then monthly x 2 months to ensure sustained compliance. Audit results will be reviewed by the Administrator and then taken to QAPI for review and recommendation. Compliance: October 17, 2022	

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	245028	A. BUILDING _____ B. WING _____	C 09/23/2022

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F 825	Continued From page 21 evaluate and treat. R3's occupation therapy evaluation and plan of treatment dated 9/2/22, indicated R3 was to receive occupation therapy three to five times a week for 30 days. R3's physical therapy evaluation and plan of treatment dated 9/5/22, indicated R3 was to receive physical therapy three to five times a week for four weeks. R3's admission MDS dated 9/9/22, identified R1 had intact cognition. R1 needed extensive assistance with transferring and activities of daily living. R1 diagnosis included multiple fractures of pelvis due to a car accident, R3's medical record lacked any physical therapy notes from 9/6/22 to 9/11/22. R3' physical therapy visit note dated 9/12/22 showed a visit was completed. Upon interview on 9/21/22, at 8:31 a.m. R3 reported she hasn't been getting as much therapy as she was told she would be getting. She reported thinking therapy was to be daily with both occupational and physical. She stated maybe she should keep track of when they come as she wasn't sure when it was. R4's admission MDS dated 9/8/22, identified R4 had intact cognition. R4 needed extensive assistance with transferring and activities of daily living. R4 diagnosis included complete traumatic amputation of right food, cellulitis of lower limb, Type I Diabetes, and obesity.	F 825		

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F 825	Continued From page 22 R4's physician orders dated 9/9/22, indicated R4 needed occupational and physical therapy to evaluate and treat. R4's occupation therapy evaluation and plan of treatment dated 9/9/22, indicated R4 needed occupation therapy five times a week for 90 days. R4's physical therapy evaluation and plan of treatment dated 9/17/22, indicated R4 needed physical therapy three to five times a week for 30 days. Upon interview on 9/21/22, at 12:51 p.m. R4 reported he had to beg for therapy at the facility. Stating he threatened to get an attorney as he had been in the facility for nine days and physical therapy had not met with him. He stated he is fearful that the facility was negligent in his cares, and he will be suffering either medically or financially. "Physical therapy did not evaluate me for 9 days following admission; therefore, I am lying in bed declining." Upon interview on 9/22/22, at 10:24 a.m. the Nurse Practitioner reported she has heard complaints from multiple residents about not receiving their rehab services. She stated she was going to be bring this up at an IDT meeting, but they have not had any. She reported she had not heard from therapy that they were missing visits, not admitting residents within 48 hours, or changing schedules. Upon interview on 9/22/22, at 3:29 p.m. the Director of Rehabilitation Services reported the rehabilitation department has a staffing shortage. She reported she was aware that R1 returned from the hospital and since he is in the	F 825		

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F 825	Continued From page 23 Transitional Care Unit, he has standing orders to restart therapy following a hospital stay. She reported R1 probably would not be evaluated for occupation therapy until 9/23/22 and physical therapy 9/28/22. She was aware that R3 and R4 had delayed evaluations with physical therapy and again because of staffing. She stated therapy performs services up to four times per week. She verified that R1, R3 and R4 had orders for three to five times a week and stated that was an error. She reported that therapy can change orders on residents at any time. They can change the certification and that populates an order to the physician. Upon interview on 9/23/22, at 12:30 p.m. the director of nursing (DON) reported her expectation is for rehab services to evaluate the resident as soon as possible within 48 hours or less. She stated that for most of the residents on the TCU the main reason is for rehabilitation services. She was unaware of residents missing therapy or not being evaluated soon following admission. Upon interview on 9/23/22, at 1:01 p.m. the Administrator reported his expectation is for all disciplines of therapy to evaluate and start treatments as so as possible within 24 to 48 hours. The facility Management Services Agreement with the therapy agency (manager) dated, 9/2/22, the therapy agency/manager shall be free to choose both how and when to perform the services subject to completion deadlines established by the company/facility (Highland Operations). The manager will maintain compliance training and auditing.	F 825		

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F 825	Continued From page 24 A specific rehabilitation services policy was requested however none received.	F 825		