Electronically delivered
March 31, 2021

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: CCN: 245183
Cycle Start Date: March 5, 2021

Dear Administrator:

On March 24, 2021, we informed you of imposed enforcement remedies.

On March 12, 2021, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 8, 2021, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 8, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 8, 2021.

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

As we notified you in our letter of March 24, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 5, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us

Mobile: (218) 368-4467

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 September 5, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 31, 2021

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

Re: State Nursing Home Licensing Orders
Event ID: IC9C11

Dear Administrator:

The above facility was surveyed on March 9, 2021 through March 12, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH NEW HOPE, MN 55428**

(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 3/9/21, through 3/12/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 In addition, the following complaints were investigaged and found to be SUBSTANTIATED: H5183316C (MN00069226) with licensing orders issued H5183317C (MN00070516) In addition, the following complaint was investigaged and found to be UNSUBSTANTIATED: H5183315C (MN00068611) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or	21545		4/7/21

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21545	Continued From page 2 (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents received pain medications on time and in accordance with provider orders for 1 of 3 residents (R3), who had complained about pain and late medications, reviewed for significant medication errors.. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/17/21, indicated that R3 had a brief inventory	21545	R3 is free of significant medication errors including timeliness of pain medications. R3 has had a new pain assessment completed, self-administration of medication assessment completed and care plan updated to reflect those changes. Current residents with pain medications have had their medication regime and schedule reviewed to ensure optimal timing of pain medication administration.	

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21545	Continued From page 3 of mental status (BIMS) score of 15, indicating he was cognitively intact. R3's diagnoses included cerebral vascular accident which resulted in hemiparesis (weakness or inability to move on one side of the body) and radiculopathy (a condition in which one or more nerves are affected and can result in pain). R3's Care Area Assessment (CAA) dated 3/12/21, indicated R3's pain disturbed his sleep and adversely affected his mood. R3's care plan dated 9/13/20, indicated staff should anticipate the residents needs for pain relief and respond immediately to any complaint of pain, monitor/record/report to nurse resident complaint of pain treatment, and give pain medication as ordered. R3's Nursing Pain Evaluation (NPE) dated 12/16/2020, indicated R3 rated his pain at 6 out of 10 (on a scale between 1-10). The NPE indicated R3 described his pain as moderate. The NPE indicated an acceptable level of pain for R3 was 2/10. R3's medical record lacked evidence of other NPEs. R3's Physician Order (PO) dated 9/16/20, included acetaminophen (Tylenol for pain) 500 milligrams (mg) give two tablets by mouth three times a day for pain. R3' PO dated 11/25/20, included arthritis/aloe cream (for pain) 10% (percent) apply to lower back for pain topically (to skin) three times a day. R3's PO dated 12/6/20, included diclofenac sodium (anti-inflammatory for pain) gel 1% apply 2 grams transdermal (to skin) three times a day for pain.	21545	Licensed nurses have been re-educated regarding significant medication errors related to administration of pain medication. DON/designee will audit 5 MARs 3x week x 2 weeks, then 5 MARs/week x 3 weeks. Audits will be reviewed at QAPI.	

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21545	Continued From page 4 R3's Medication Administration Record (MAR) dated 3/9/21, indicated these medications were to be given at the following times: * acetaminophen 500 mg at 8:00 a.m., 2:00 p.m., and 8:00 p.m. * arthritis/aloe cream 10% topically at 7:00 a.m., 5:00 p.m., and 8:00 p.m. * diclofenac sodium gel 1% transdermal at 8:00 a.m., 12:00 p.m., and 5:00 p.m. R3's MAR indicated the pain medication arthritis/aloe cream 10% was administered late 40 out of 84 opportunities for the time period 2/8/21, to 3/8/21. R3's MAR also indicated pain medication diclofenac sodium gel 1% was administered late 43 out of 84 opportunities for the time period 2/8/21, to 3/8/21. During continuous observation on 3/9/2021, between 9:42 a.m. and 10:00 a.m. registered nurse (RN)-A administered acetaminophen 500 mg, arthritis/aloe cream 10%, and diclofenac sodium gel 1%. When interviewed on 3/9/21, at 10:22 a.m., registered nurse (RN)-A confirmed medications were administered late and stated medications were to be given one hour before to one hour after the scheduled time. RN-A stated when medications were administered late the provider was to be updated and a note placed in the progress notes. When interviewed on 3/9/21, at 10:43 a.m., licensed practical nurse (LPN)-A stated medications given one hour before or after scheduled time was acceptable. If administration of medications were late (more than an hour) then the provider would be notified and this would	21545		

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21545	Continued From page 5 be expected to be documented in the electronic medical record (EMR). When interviewed on 3/9/21, at 10:53 a.m., R3 stated he had pain in both legs, back, and both arms. R3 stated, "sometimes I don't get my pain meds" despite using call light to notify staff of pain. R3 stated sometimes he did not use his call light but rather, he called the nurse manager directly to complain, which resulted in him getting his pain medications. R3 indicated late medications occurred frequently and was a source of frustration because his pain was not controlled. When interviewed on 3/11/21, at 11:27 a.m., RN-B stated the rule of one hour before or after scheduled time was acceptable for a medication to be given on time. If a medication were given late the staff would be expected to update the provider and document this in the EMR. RN-B stated staff were instructed to document at the time of administration. RN-B verified R3's arthritis/aloe cream 10% was scheduled for 7:00 a.m. and administered over 2 hours late. RN-B also verified R3's diclofenac sodium gel 1% was scheduled for 8:00 a.m. and administered over 1 hour late. RN-B stated R3 had informed her R3 had filed a report with the State Agency (SA) because he was so upset about ongoing late pain medication administration. During an interview on 3/11/21, at 5:44 p.m., the director of nursing (DON) stated the expectation was medications administered one hour before or one hour after it was scheduled and if it was outside that timeframe, it would be considered late. The DON indicated the facility's MAR system would auto-populate routine scheduled times for medications to be administered unless a	21545		

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21545	Continued From page 6 physician orders specific times. For example, three times per day medications would be expected to be administered at 8:00 a.m., 12:00 p.m., and 8:00 p.m. which was what R3's pain medications diclofenac sodium gel 1% and acetaminophen were scheduled for. The DON verified R3's pain medications were administered late and there were no progress notes to state any of his medications were administered late or the physician was notified. The DON indicated the 8:00 a.m. dose given at 10:05 a.m. would need to have the scheduled 12:00 p.m. dose adjusted to another time to ensure therapeutic effect. The DON stated the staff were expected to notify the provider of late significant medication administration and to document this in the progress note of the EMR. The facility Medication Administration Schedule Policy dated 1/20, indicated medications were to be administered per community protocol and that physician's orders for specific times would supercede any routine schedule. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

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E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 3/9/21, through 3/12/21, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance with this regulation. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted between 3/9/21, and 3/12/21, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined to NOT to be in compliance. In addition, the following complaints were investigated and found to be SUBSTANTIATED: H5183316C (MN00069226) with deficiencies cited at F760 H5183317C (MN00070516) with deficiencies cited at F880 The following complaint was investigated and found to be UNSUBSTANTIATED: H5183315C (MN00068611) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your	F 000		

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

Electronically Signed | 04/01/2021

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F 000	Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents received pain medications on time and in accordance with provider orders for 1 of 3 residents (R3), who had complained about pain and late medications, reviewed for significant medication errors.. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/17/21, indicated that R3 had a brief inventory of mental status (BIMS) score of 15, indicating he was cognitively intact. R3's diagnoses included cerebral vascular accident which resulted in hemiparesis (weakness or inability to move on one side of the body) and radiculopathy (a condition in which one or more nerves are affected and can result in pain). R3's Care Area Assessment (CAA) dated 3/12/21, indicated R3's pain disturbed his sleep	F 760	R3 is free of significant medication errors including timeliness of pain medications. R3 has had a new pain assessment completed, self-administration of medication assessment completed and care plan updated to reflect those changes. Current residents with pain medications have had their medication regime and schedule reviewed to ensure optimal timing of pain medication administration. Licensed nurses have been re-educated regarding significant medication errors related to administration of pain medication. DON/designee will audit 5 MARs 3x week x 2 weeks, then 5 MARs/week x 3 weeks. Audits will be reviewed at QAPI.	4/7/21

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F 760	Continued From page 2	F 760		

and adversely affected his mood.

R3's care plan dated 9/13/20, indicated staff should anticipate the residents needs for pain relief and respond immediately to any complaint of pain, monitor/record/report to nurse resident complaint of pain treatment, and give pain medication as ordered.

R3's Nursing Pain Evaluation (NPE) dated 12/16/2020, indicated R3 rated his pain at 6 out of 10 (on a scale between 1-10). The NPE indicated R3 described his pain as moderate. The NPE indicated an acceptable level of pain for R3 was 2/10. R3's medical record lacked evidence of other NPEs.

R3's Physician Order (PO) dated 9/16/20, included acetaminophen (Tylenol for pain) 500 milligrams (mg) give two tablets by mouth three times a day for pain.

R3' PO dated 11/25/20, included arthritis/aloe cream (for pain) 10% (percent) apply to lower back for pain topically (to skin) three times a day.

R3's PO dated 12/6/20, included diclofenac sodium (anti-inflammatory for pain) gel 1% apply 2 grams transdermal (to skin) three times a day for pain.

R3's Medication Administration Record (MAR) dated 3/9/21, indicated these medications were to be given at the following times:
* acetaminophen 500 mg at 8:00 a.m., 2:00 p.m., and 8:00 p.m.
* arthritis/aloe cream 10% topically at 7:00 a.m., 5:00 p.m., and 8:00 p.m.
* diclofenac sodium gel 1% transdermal at 8:00

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a.m., 12:00 p.m., and 5:00 p.m.

R3's MAR indicated the pain medication arthritis/aloe cream 10% was administered late 40 out of 84 opportunities for the time period 2/8/21, to 3/8/21. R3's MAR also indicated pain medication diclofenac sodium gel 1% was administered late 43 out of 84 opportunities for the time period 2/8/21, to 3/8/21.

During continuous observation on 3/9/2021, between 9:42 a.m. and 10:00 a.m. registered nurse (RN)-A administered acetaminophen 500 mg, arthritis/aloe cream 10%, and diclofenac sodium gel 1%.

When interviewed on 3/9/21, at 10:22 a.m., registered nurse (RN)-A confirmed medications were administered late and stated medications were to be given one hour before to one hour after the scheduled time. RN-A stated when medications were administered late the provider was to be updated and a note placed in the progress notes.

When interviewed on 3/9/21, at 10:43 a.m., licensed practical nurse (LPN)-A stated medications given one hour before or after scheduled time was acceptable. If administration of medications were late (more than an hour) then the provider would be notified and this would be expected to be documented in the electronic medical record (EMR).

When interviewed on 3/9/21, at 10:53 a.m., R3 stated he had pain in both legs, back, and both arms. R3 stated, "sometimes I don't get my pain meds" despite using call light to notify staff of pain. R3 stated sometimes he did not use his call

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light but rather, he called the nurse manager directly to complain, which resulted in him getting his pain medications. R3 indicated late medications occurred frequently and was a source of frustration because his pain was not controlled.

When interviewed on 3/11/21, at 11:27 a.m., RN-B stated the rule of one hour before or after scheduled time was acceptable for a medication to be given on time. If a medication were given late the staff would be expected to update the provider and document this in the EMR. RN-B stated staff were instructed to document at the time of administration. RN-B verified R3's arthritis/aloe cream 10% was scheduled for 7:00 a.m. and administered over 2 hours late. RN-B also verified R3's diclofenac sodium gel 1% was scheduled for 8:00 a.m. and administered over 1 hour late. RN-B stated R3 had informed her R3 had filed a report with the State Agency (SA) because he was so upset about ongoing late pain medication administration.

During an interview on 3/11/21, at 5:44 p.m., the director of nursing (DON) stated the expectation was medications administered one hour before or one hour after it was scheduled and if it was outside that timeframe, it would be considered late. The DON indicated the facility's MAR system would auto-populate routine scheduled times for medications to be administered unless a physician orders specific times. For example, three times per day medications would be expected to be administered at 8:00 a.m., 12:00 p.m., and 8:00 p.m. which was what R3's pain medications diclofenac sodium gel 1% and acetaminophen were scheduled for. The DON verified R3's pain medications were administered

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F 760	Continued From page 5 late and there were no progress notes to state any of his medications were administered late or the physician was notified. The DON indicated the 8:00 a.m. dose given at 10:05 a.m. would need to have the scheduled 12:00 p.m. dose adjusted to another time to ensure therapeutic effect. The DON stated the staff were expected to notify the provider of late significant medication administration and to document this in the progress note of the EMR. The facility Medication Administration Schedule Policy dated 1/20, indicated medications were to be administered per community protocol and that physician's orders for specific times would supercede any routine schedule.	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		4/7/21

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F 880	Continued From page 6 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 7 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview. and document review, the facility failed to ensure staff wore personal protective equipment (PPE) when caring for 3 of 3 residents (R4, R6, and R7) and failed to disinfect high touch surfaces for 1 of 1 residents (R1) who were reviewed for infection control. Findings Include: PPE USE BY STAFF R4's discharge Minimum Data Set (MDS), 3/10/21, indicated R4 was over 70 years old, admitted within 14 days, and had diagnoses of respiratory failure, heart failure, high blood pressure, and high cholesterol. R6's significant change MDS 3/9/21, indicated R6 was over 70 years old, admitted within 14 days, and had diagnoses of respiratory failure, diabetes, kidney disease, high blood pressure and high cholesterol. R7's admission MDS dated 3/13/21, indicated R7 was over 65 years old and had diagnoses of respiratory failure, heart failure, and high cholesterol. During continuous observation on 3/9/21, from 1:38 p.m. through 1:47 p.m., health unit coordinator (HUC)-A walked out of R4's room	F 880	R4, R6, and R7 are receiving cares with staff utilizing appropriate PPE and infection control practices. R1 has been discharged from the facility and the room has been disinfected; including high touch areas. Current residents are receiving cares with staff utilizing appropriate PPE and infection control practices. Staff have been re-educated regarding appropriate use of PPE, appropriate techniques to ensure gown and mask placement, and appropriate hand hygiene requirements. Housekeeping staff have been re-educated regarding cleaning of high touch surfaces, including light switch plates. High touch surfaces are being cleaned twice daily in isolation units and once daily throughout the rest of the facility. Infection Preventionist/designee will audit 30 staff members/week x 2 weeks, then 15 staff members/week x 2 weeks for compliance. Housekeeping Manager/designee will audit housekeeping service on 5 units/week x 2 weeks, then 3 units/week x 2 weeks; ensuing high touch surfaces and being	

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F 880	Continued From page 8 wearing a face mask and no eye protection along with R4's family member (FM)-A. A few minutes later, HUC-A and FM-A re-entered R4's room and exited again at 1:47 p.m. During an interview on 3/9/21, at 1:47 p.m. HUC-A stated she should be wearing eye protection in resident areas, including the hallways and in the resident rooms. HUC-A stated she forgot her eye protection but she usually wore it. During an observation on 3/9/21, at 2:15 p.m. nursing assistant (NA)-B exited R6's room and then entered R7's room while wearing a KN-95 face mask below nose and no eye protection. NA-B did not perform hand hygiene after exiting R6's room or before entering R7's room. NA-B also wore the same gown when exiting R6's room and entering R7's room. During an interview on 3/9/21, at 2:15 p.m. NA-B stated she had problems with her mask staying up and the blue mask (surgical masks) fit better. NA-B stated she forgot her eye protection because she was running late. NA-B confirmed R6 and R7 were on quarantine because they were new admissions. NA-B agreed her mask should be above her nose and she should perform hand hygiene after adusting her mask. NA-B stated gowns should be removed when leaving the room of a resident in quarantine. During an observation on 3/9/21, at 2:30 p.m. NA-B entered R7's room to assist registered nurse (RN)-K. NA-B wore a facemask, that would drop under her nose, a gown that was tied at the neck only, gloves and no eye protection. NA-B leaned over to pick trash and linens off the floor,	F 880	appropriately disinfected. Audits will be reviewed at QAPI.	

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F 880	Continued From page 9	F 880		

allowing the gown ties to fall forward and drag on the floor. NA-B removed gloves and performed hand hygiene. NA-B pushed her mask over her nose and then placed a gown on R7, without changing gloves or performing hand hygiene after touching her mask. The front of NA-B's gown and ties that had touched the floor touched R7's bed while NA-B was placing a cover sheet over R7. NA-B's mask dropped under her nose and she used her hand to push the mask over her nose. NA-B then placed a pillow under R7's head without changing gloves or performing hand hygiene after she touched her facemask. NA-B doffed the gown in the room and performed hand hygiene on exiting the room.

During an interview on 3/9/21, at 1:49 p.m. RN-F stated the expectation was all staff wear facemasks and eye protection in resident care areas, which included the hallways and resident rooms. RN-F stated the facility had plenty of PPE for staff to use.

During an interview on 3/11/21, around 4:15 p.m. with the director of nursing (DON), the infection preventionist (IP), and the Regional Clinical Nurse (RCN), the IP stated the expectation was staff would wear masks and eye protection in resident care areas, and gowns when caring for a resident in quarantine or transmission based precautions requiring a gown. THe IP further stated the gown should be removed prior to leaving a quarantine room.

The facility's Personal Protective Equipment F880 policy dated 5/2020, indicated use of PPE during a pandemic was guided by the CDC.

The Minnesota Department of Health, Long-term

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F 880	Continued From page 10	F 880		

Care (LTC) Toolkit, dated 3/9/21, based upon CDC guidelines, indicated LTC "employees participating in universal masking initiatives will wear well-fitting face masks" and all staff should wear a well-fitting face mask at all times when in the facility. Medical-grade surgical masks should be prioritized for direct care personnel if they are in short supply. The Toolkit also indicated eye protection should be worn when staff are in resident care areas. Finally, the Toolkit indicated full PPE for staff, including gowns, should be worn for 14 days following a new admision, readmission, or after exposure to COVID-19.

CLEANING HIGH TOUCH SURFACES

R1's annual MDS dated 11/9/20, indicated R1 was 79 years old and had diagnoses of respiratory failure, renal failure, heart disease, high blood pressure, diabetes, and high cholesterol. R1's discharge MDS dated 3/5/21, indicated R1 died on 3/5/21.

During an observation on 3/9/21, at 3:10 p.m. a small red smear was observed on the light switch cover in R1's room, which did not have a current resident living there. The red smear was consistent with photos of a red smear taken by R1's family member (FM)-A on 3/1/21, 3/2/21, and 3/5/21.

During an interview on 3/9/21, at 3:13 p.m. licensed practical nurse (LPN)-B exclaimed, "that looks like blood" when shown the light switch cover in R1's room. LPN-B brought an antimicrobial/bleach wipe to R7's room and cleaned the light switch cover. LPN-B stated rooms were to be cleaned every day and high-touch surfaces, like the light switch cover

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F 880	Continued From page 11	F 880		

should be cleaned every day. LPN-B stated when a resident was discharged, the room had everything sanitized.

During an interview on 3/10/21, at 9:52 a.m., FM-A stated the facility did not clean while she was there and noted high touch surfaces, like the light switch cover, should be cleaned at least daily. FM-A stated she took a picture of the dirty light switch cover each day over several days (3/1/21, 3/2/21, and 3/5/21) to show this high touch surface was not cleaned. FM-A stated she showed this to RN-C, who thought it looked like ketchup but agreed it should not be there. FM-A stated it was still there on the day R1 died.

During an interview on 3/19/21, at 10:45 a.m., the director of housekeeping and laundry (DOHL) stated housekeeping staff were responsible for routine cleaning of public areas and resdient rooms. The DOHL stated high touch surfaces, like hand rails, light switches, doorknobs, elevator buttons, should be cleaned twice a day - at the beginning of the shift and before they go home at 2:30 p.m. Upon discharge, a resident's room should be stripped, bed sanitized, curtains washed, and everything in the room sanitized.

During an interview on 3/11/21, around 4:15 p.m with the director of nursing (DON), the infection preventionist (IP), and the Regional Clinical Nurse (RCN), the IP stated the expectation was high touch areas would be cleaned at least once a day.

The facility's Cleaning and Disinfection of Environmental Surfaces F 880 policy dated 1/2020, indicated environmental surfaces would be cleaned and disinfected according to CDC

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F 880	Continued From page 12 recommendations. The facility's Checklist for Infection Control undated, indicated high touch surfaces, incluidng light switches would be cleaned three times a day. The CDC guidelines, dated 1/5/21, indicated frequently touched surfaces should be cleaned at least daily.	F 880		