



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 15, 2022

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

RE: CCN: 245277
Cycle Start Date: October 27, 2022

Dear Administrator:

On October 27, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 15, 2022.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 15, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 15, 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:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292; 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 December 15, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Waterview Woods LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 15, 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 April 27, 2023 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)

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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/ltr_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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized flourish at the end.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Electronically delivered
November 15, 2022

Administrator
The Waterview Woods LLC
601 Grant Avenue
Eveleth, MN 55734

Re: State Nursing Home Licensing Orders
Event ID: UVF611

Dear Administrator:

The above facility was surveyed on October 25, 2022 through October 27, 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 Waterview Woods LLC

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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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/27/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW WOODS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 601 GRANT AVENUE EVELETH, MN 55734		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 10/25/22 and 10/27/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52775141C (H00087658), H52775356C (MN00087659), H52775142C (MN00087657) with deficiencies cited at F677, F686, F692, and 880. 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance and incontinence care for 3 of 3 residents (R2, R3, R5) who were dependent upon	F 677	F677 ADL Care Immediate Corrective Action: Resident 2, 3, and 5 all received	12/2/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE
11/23/2022

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 677	Continued From page 1 staff for care. Findings include: R2's quarterly minimum data set (MDS) dated 9/19/22, identified moderately impaired cognition and diagnoses of diabetes mellitus (DM), hemiplegia (weakness on one side), and at risk for pressure ulcers. R2 required extensive assistance of one for personal hygiene, bed mobility, dressing, toilet use, and total dependence with transfers. R2 also received an anticoagulant and diuretic (water pill) daily and always incontinent of bowel and bladder. R2's care plan dated 3/15/22, listed various interventions which included turn and reposition or reminders to offload every 2 to 3 hours and as needed, required assist with movement in bed and in/out of bed and assist of 1 with toileting. R2's Braden scale (tool used to determine pressure ulcer risk) dated 9/19/22, identified mild risk for skin breakdown, very limited mobility, and potential for a problem with friction and shear, was chairfast, alert and oriented with confusion, and could not always communicate discomfort or need to be turned. directed staff were expected to check and change R2 and provide reminders for repositioning and offloading every 2 hours and PRN. R2's nursing assistant record (NAR) care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet last void 11:00 a.m., 8 hours later at 9:00 p.m. documented as incontinent.	F 677	toileting/incontinence care. Corrective Action as it applies to others: Care Planning Policy was reviewed and remain current. All residents who require toileting/incontinence care were reviewed to ensure that this reflected on NAR care sheets and care plan. All nurses/TMAs/CNAs were educated on need to provide toileting/incontinence care to residents per their individualized care plan. Date of Compliance: 12/2/22 Recurrence will be prevented by: 5 residents that require toileting assistance/incontinence care will be audited to ensure that they have received care within the timeframe noted on care plan/sheets. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee		

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F 677	Continued From page 2 -on 10/24/22, night shift care sheet last void at 9:00 p.m., 3 hours later at 12:00 a.m. incontinent, 4:00 a.m. incontinent, and 4th round no documentation for check and change. -on 10/25/22, day shift care sheet last void 4:00 a.m., over 4 hours later at 8:15 a.m. incontinent, 10:15 a.m., and 4th round no documentation for check and change. -on 10/25/22, evening shift care sheet last void 8:15 a.m. over 6 ½ hours at 2:56 p.m. incontinent, and over 6 hours later at 8:55 p.m. incontinent. -on 10/25/22, night shift care sheet last void 8:55 p.m. over 4 hours later at 12:06 a.m. incontinent/BM, 2:08 a.m. and 4:36 a.m. both times incontinent. -on 10/26/22, day shift care sheet last void at 4:20 a.m. at 7:17 a.m. dry, 8:20 a.m. repositioned, 10:41 a.m. incontinent and 1:00 p.m. dry. -on 10/26/22, evening shift care sheet last void at 10:41 a.m., over 3 ½ hours later at 2:40 p.m. incontinent, over 3 hours later at 6:13 p.m. incontinent, and again at 3 hours later at 9:53 p.m. dry. -on 10/26/22, night shift care sheet last void at 6:13 p.m., over 6 hours later at 12:20 a.m. incontinent, 1:36 a.m. dry, 3:00 a.m. incontinent, and 4th round no documentation of check and change. During an observation on 10/25/22, at 10:33 a.m. NA-B and NA-E entered R2's room, placed lift sheet underneath R2 and transferred her from wheelchair to the bed. NA-E asked R2 if her brief was wet and R2 stated no. NA-B checked the brief and it was wet. NA-B asked R2 if they could change her brief and she stated yes. NA-B pulled R2's pants down to her knees and pulled back the brief wet with urine and tucked it between her legs. NA-B wiped from front to back with	F 677			

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F 677	Continued From page 3 moistened wipe. R2's labia was slightly red. NA-B applied a barrier cream to the outer side of the labia with gloves on. NA-E rolled R2 onto her left side and identified a red area on R2's coccyx and verified it measured approximately 4 inches long by ½ inch wide. NA-B applied barrier cream to coccyx area and also verified there were no open areas noted. NA-B stated he had already informed the staff nurse about the red area on R2's coccyx. NA-B stated R2 liked to sit up in her wheelchair and go out and smoke. R2 was rolled onto her left side, placed a pillow underneath her back/buttocks area, covered with a blanket, and raised the head of the bed (HOB) approximately 40 degrees. NA-B and NA-E both removed their gloves, washed their hands, and exited the room. During observations on 10/25/22, R2 laid in bed from 10:33 a.m. to 3:30 p.m. identified: - at 10:45 a.m. R2 laid on back with head of bed (HOB) up to approximately 40 degrees awake. -at 11:15 a.m. R2 laid on back with HOB up to approximately 40 degrees eyes are closed. -at 12:00 p.m. LPN- B entered R2's room placed a small cup of supplement in front of her on the bedside table and exited the room. R2 laid on her back with HOB up to 40 degrees awake. -at 1:10 p.m., 1:46 p.m., 2:05 p.m., and 2:44 p.m., R2 laid in bed awake on her back positioned unchanged with HOB up to 40 degrees. -at 3:30 p.m. R2 laid in bed on her back awake positioned unchanged. R2 stated she had not been changed or repositioned since before lunch. R3's quarterly MDS dated 7/20/22, identified moderately impaired cognition, diagnosis of peripheral vascular disease, and at risk for pressure ulcers. R3 required extensive assistance of one for personal hygiene, transfers,	F 677			

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F 677	Continued From page 4 dressing, toileting use, and bed mobility, and continent of bowel and bladder. R3's care plan updated 6/28/22, listed various interventions which included assist of 1 with toileting, and transfers, monitor skin integrity daily during cares and weekly skin inspection by nurse, pressure redistribution mattress to bed and cushion to wheelchair, and monitor for skin breakdown for signs/symptoms of infection. R3's Braden scale dated10/18/22, moderate risk for skin breakdown. R3 was incontinent of bowel and bladder, wears incontinence briefs. R3 was to be checked and changed every two hours. R3's NAR care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet. Last void 1:05 p.m. on day shift and over 7 ½ hours later 9:04 p.m. incontinent/BM. -on 10/24/22, night shift care sheet. Last void 9:04 p.m. Then three hours later at 12:05 p.m., 2:07 a.m., 4:05 a.m. incontinent all three times. The 4th round no check and change was documented. -on 10/25/22, day shift care sheet. Last void at 4:05 a.m. on night shift. Three hours later at 7:05 a.m. and 9:10 a.m. dry both times. At 11:45 a.m. and 1:00 p.m. incontinent. -on 10/25/22, evening shift care sheet. Last void at 1:00 p.m. on day shift and over 8 ½ hours later at 9:47 p.m. incontinent/BM. -on 10/25/22, night shift care sheet. Last void at 9:47 p.m. then at 12:06 a.m., 2:08 a.m., and 4:30 a.m. R3 was incontinent, and 4th round no check and change was documented. -on 10/26/22, day shift care sheet. Last void at	F 677			

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F 677	Continued From page 5 4:30 a.m. and 5 hours later at 9:30 a.m. bed change. -on 10/26/22, evening shift care sheet. Last void at 9:30 a.m. then 5 ½ hours later at 3:00 p.m. incontinent, 5:00 p.m. incontinent, and over 4 hours later at 9:52 p.m. incontinent. -on 10/26/22, night shift care sheet. Last void at 9:52 p.m. at 12:23 a.m. R3 refused, 3 ½ hours later at 1:40 a.m. incontinent, and 4th round no check and change documented. -on 10/27/22, day shift care sheet. Last void at 1:40 a.m. and over three hours later at 4:46 a.m. incontinent. During observations/interviews on 10/25/22, from 9:15 a.m. to 1:00 p.m.: -at 9:15 a.m. R3 laid on left side with and legs hung over the side of the bed eating breakfast. -at 9:18 a.m., 9:57 a.m., 10:22 a.m., 10:30 a.m., 11:25 a.m., R3 laid in bed on her back, knees up, head of bed (HOB) up approximately 40 degrees and with lights off. -at 11:40 a.m. R3 laid in bed, knees up. -at 12:15 p.m. R3 sat up in bed, leaned over and was observed picking up popcorn off the floor. NA-F entered R3's room with lunch on a tray. NA-F stated out loud "your bed is dirty, ugh"! NA-F also stated looks like we need to get in here and get you cleaned up for the day. NA-F suggested R3 eat lunch first then staff would help her after that. -at 12:37 p.m. during an interview R3 placed her call light on and stated she stayed in bed all day long and ate her meals her room. R3 also stated staff come in to change her. R3 verified it had been a while since she had been changed and needed help because she wore a brief and currently it was wet. -at 12:50p.m. NA-E entered R3's room and	F 677			

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F 677	Continued From page 6 informed her she was going to get her cleaned up for the day. R3 requested surveyor leave room for privacy. -at 1:00 p.m. during an observation/interview NA-E opened R3's door carrying a bag of dirty linen and garbage. NA-E interviewed at that time and stated R3 used her call light "at times". NA-E also stated R3 had been incontinent of urine and an extra small bowel movement. NA-E verified R3 does not alert staff when she was wet and needed to be checked and changed every 2 hours. NA-E also verified R3's incontinent brief and lift sheet located directly underneath her was both soiled with urine/stool and had to be changed. NA-E stated it was a bit late today when R3 got cleaned up but she likes to stay in bed and that she was not sure the last time she was checked on but it would most likely be on the nurse aide care sheet that staff fill out each shift. Review of NAR care sheet (above) indicated R3 was incontinent at 11:45 a.m. and presumably changed. This documentation is inconsistent with observation and interview, given R3 had soaked through both her incontinent brief and lift sheet when changed by NA-E at 12:50 p.m. R5's quarterly MDS dated 4/22/22, identified severely impaired cognition and diagnosis of dementia. R5 required extensive assistance of one for personal hygiene, dressing, bed mobility, extensive assistance of two for toileting and transfers, and supervision of cuing and encouragement with locomotion on and off the unit. R5's MDS also identified always incontinent of bladder and frequently incontinent of bowel and at risk for pressure ulcers. R5's care plan updated 6/20/22, listed various	F 677			

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F 677	Continued From page 7 interventions which included Hoyer lift for all transfers, provide assist with bed mobility to sit up, boost up and get feet in and out of bed, turn and reposition and offload every 2 hours and as needed (PRN). Additionally, R5 required assist of 2 with toileting and transfers, extensive assist of 1 for hygiene and clothing adjustment, weekly skin audits with bath or shower, pressure redistribution mattress to bed and wheelchair, and assist with movement in bed. R5's NAR care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet last void at 11:50 a.m. over 7 hours at 7:45 p.m. incontinent, and 9:16 p.m. incontinent. -on 10/24/22, night shift care sheet last void at 9:16 p.m., 12:23 a.m. incontinent, 2:23 a.m. incontinent, 4:20 a.m. incontinent, and 4th round no check and change was documented. -on 10/25/22, day shift care sheet last void at 4:20 a.m., over 2 1/2 hours at 7:15 a.m. incontinent, 3rd round no check and change was documented, and over 6 ½ hours at 2:00 p.m. incontinent. -on 10/25/22, evening shift care sheet last void at 2:00 p.m. over 4 ½ hours at 6:58 p.m. incontinent, and 9:12 p.m. incontinent. -on 10/25/22, night shift care sheet last void at 9:12 p.m., over 3 hours at 12:23 a.m. incontinent, 4:30 a.m. incontinent, and 4th round no check and change was documented. -on 10/26/22, day shift care sheet last void at 4:30 a.m. 6:00 a.m. 11:05 a.m. incontinent, and 12:50 p.m. incontinent. -on 10/26/22, evening shift care sheet last void at 12:50 p.m., over 6 hours at 7:10 p.m. incontinent, and 9:45 p.m. incontinent.	F 677			

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F 677	Continued From page 8 -on 10/26/22, night shift care sheet last void at 9:45 p.m., over 2 hours at 12:07 a.m. incontinent, 2:10 a.m. incontinent, 4:20 a.m. incontinent. During observations on 10/25/22, from 9:36 a.m. of R5 identified: -at 9:36 a.m. R5 sat in wheelchair in dining room next the window with her cloth protector still on from breakfast. -at 10:48 a.m. R5 sat in dining room still had clothing protector on from breakfast. R5 faced the window pulled, and folded panel curtain of windows. -at 11:30 a.m. R5 is sat in dining room same position, location, and still had clothing protector on. -at 12:16 p.m. R5 ate lunch with assistance in dining room used same clothing protector from breakfast, no observation of R5 leaving dining area for check and change before lunch. -at 12:46 p.m. R5 still sitting in dining room appeared to be done eating and still drinking. -at 2:00 p.m. NA-B entered the dining room and asked R5 if she was ready to use the bathroom. NA-B pushed R5 in wheelchair out of dining room, down the hallway, and into the bath/toileting room. NA-B used the ceiling lift to transfer R5 from wheelchair to toilet. R5 was incontinent of urine and stool and incontinence product was observed to be saturated. While observing NA-B stated staff are assigned to a hallway and they work as a team to make sure all the residents are getting their check and changes completed. NA-B also stated staff use a nursing assistant record (NAR) sheet they sign off what has been completed. NA-B verified R5 sometimes used a call light but when she sat in the dining room would most likely would not have told a staff if she needed the bathroom. NA-B	F 677			

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F 677	Continued From page 9 stated any of the staff that worked in this hallway would have been responsible to check and change R5 but would have to look at the NAR sheet to see who checked on her last and what time. Review of R5's NAR care sheet indicated she did not receive a check and change for 6 ½ hours before getting changed at 2 p.m. on 10/25/22. During an interview on 10/26/22, at 10:31 a.m. NA-G stated there was a big issue with some staff not completing check and changes correctly. NA-G indicated some residents did not receive adequate check and changes and sat in their urine and feces longer than appropriate. NA-G also stated this had been reported before and it was investigated but no real improvement was made. During an interview on 10/26/22, at 11:35 a.m. director of nursing (DON) stated if a resident was independent staff would be expected to have checked on them and identify what they did for them on the NAR care sheet. DON also stated if a resident required assistance to remain continent and/or repositioning that should be identified on the NAR sheet with repo, and I/C (Incontinent/Continent). During an interview on 10/26/22, at 3:50 p.m. RN-A staff are expected to document the residents needs such as when they were last toileted or checked and changed on the NAR care sheets. RN-A indicated she expected the floor nurse to check the NAR sheets at the end of the shift to identify if the toileting is being completed. RN-A stated staff are expected to use the same codes to document on the NAR care	F 677			

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F 677	Continued From page 10 sheets such as D for dry and I for incontinent. RN-A verified there had been many times staff had complained the documentation was not being done. During an interview on 10/27/22, at 11:08 a.m. NA-C stated R2 required total assistance of two for incontinence cares and repositioning. NA-C staff are expected to check and change and reposition R2 every two hours. NA-C stated R3 required total assistance with cares with two staff. NA-C indicated staff are to document toileting and check and changes on the NAR care sheets and currently the repositioning should be documented on there also. NA-C verified R5 was total assistance at all times of two staff and staff were expected to toilet her at least every two hours or less.	F 677			
F 686 SS=D	Toileting and incontinence care policy was requested but not received. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686			12/2/22

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F 686	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was offered and weekly skin assessments completed for 4 of 5 residents (R2, R3, R4, R5,) reviewed who were at risk for development of pressure ulcers. Findings include: R2's quarterly minimum data set (MDS) dated 9/19/22, identified moderately impaired cognition and diagnoses of diabetes mellitus, hemiplegia (weakness on one side), and at risk for pressure ulcers. R2 required extensive assistance of one for personal hygiene, bed mobility, dressing, toilet use, and total dependence with transfers. R2 also received an anticoagulant and diuretic (water pill) daily and always incontinent of bowel and bladder. R2's care plan dated 3/15/22, listed various interventions which included monitor skin integrity daily during cares, weekly skin inspection by nurse, turn and reposition or reminders to offload every 2 to 3 hours and as needed, pressure redistribution mattress to bed and wheelchair. Additionally, R2 required assist with movement in bed and in/out of bed and assist of 1 with toileting. R2's Braden scale (tool used to determine pressure ulcer risk) dated 9/19/22, identified mild risk for skin breakdown, very limited mobility, and potential for a problem with friction and shear, was chairfast, alert and oriented with confusion, and could not always communicate discomfort or need to be turned. Staff were expected to check	F 686	F686 Treatment/Svcs to Prevent PU Immediate Corrective Action: Resident 2, 3, 4, and 5 all were repositioned. Corrective Action as it applies to others: Skin Assessment and Wound Management Policy and Care Planning Policy were reviewed and remain current. All residents who are at high risk and require repositioning by staff were reviewed to ensure that this reflected on NAR care sheets and care plan. All residents were reviewed to ensure that they have had a weekly skin check documented within the last week. All nurses/TMAs/CNAs were educated on need to provide repositioning to residents per their individualized care plan. All nurses were educated on need to complete a weekly skin check on resident's bath day even if they refuse the bath. TMAs were educated to notify floor nurse to complete skin check if it came up on TAR to be completed. Date of Compliance: 12/2/22 Recurrence will be prevented by: 5 residents will be audited to ensure that they have had a weekly skin check		

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F 686	Continued From page 12 and change R2 and provide reminders for repositioning and offloading every 2 hours and PRN. Weekly skin checks to be completed on R2 an notify licensed nurse of any noted skin changes. Review of R2's Weekly skin inspection dated 10/6/22, identified no changes to skin. The skin assessment document also indicated it was the nurses responsibility to evaluate the residents skin at minimum once a week to ensure skin integrity and implement interventions as applicable. There was no evidence of weekly skin assessments were complted after 10/6/22. Review of R2's nursing assistant report (NAR) care sheets 10/24/22 through 10/26/22, provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: R2's nursing assistant record (NAR) care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet last void 11:00 a.m., 8 hours later at 9:00 p.m. documented as incontinent. -on 10/24/22, night shift care sheet last void at 9:00 p.m., 3 hours later at 12:00 a.m. incontinent, 4:00 a.m. incontinent, and 4th round no documentation for check and change. -on 10/25/22, day shift care sheet last void 4:00 a.m., over 4 hours later at 8:15 a.m. incontinent, 10:15 a.m., and 4th round no documentation for check and change. -on 10/25/22, evening shift care sheet last void 8:15 a.m. over 6 ½ hours at 2:56 p.m. incontinent, and over 6 hours later at 8:55 p.m. incontinent. -on 10/25/22, night shift care sheet last void 8:55	F 686	completed/documented. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. 5 residents who require repositioning assistance will be audited to ensure that they have been repositioned per their individualized care plan. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee		

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F 686	Continued From page 13 p.m. over 4 hours later at 12:06 a.m. incontinent/BM, 2:08 a.m. and 4:36 a.m. both times incontinent. -on 10/26/22, day shift care sheet last void at 4:20 a.m. at 7:17 a.m. dry, 8:20 a.m. repositioned, 10:41 a.m. incontinent and 1:00 p.m. dry. -on 10/26/22, evening shift care sheet last void at 10:41 a.m., over 3 ½ hours later at 2:40 p.m. incontinent, over 3 hours later at 6:13 p.m. incontinent, and again at 3 hours later at 9:53 p.m. dry. -on 10/26/22, night shift care sheet last void at 6:13 p.m., over 6 hours later at 12:20 a.m. incontinent, 1:36 a.m. dry, 3:00 a.m. incontinent, and 4th round no documentation of check and change. R2's NAR care sheets lacked repositioning documentation. During intermittent observations on 10/25/22, R2 laid in bed from 10:33 a.m. to 3:30 p.m. (confirmed by documentation): -at 10:33 a.m. NA-B and NA-E entered R2's room, placed lift sheet underneath R2 and transferred her from wheelchair to the bed. NA-E asked R2 if her brief was wet and R2 stated no. NA-B checked the brief and it was wet. NA-B asked R2 if they could change her brief and she stated yes. NA-B pulled R2's pants down to her knees and pulled back the brief wet with urine and tucked it between her legs. NA-B wiped from front to back with moistened wipe. R2's labia was slightly red. NA-B applied a barrier cream to the outer side of the labia with gloves on. NA-E rolled R2 onto her left side and identified a red area on R2's coccyx and verified it measured approximately 4 inches long by ½ inch wide.	F 686			

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F 686	Continued From page 14 NA-B applied barrier cream to coccyx area and also verified there were no open areas noted. NA-B stated he had already informed the staff nurse about the red area on R2's coccyx. NA-B stated R2 liked to sit up in her wheelchair and go out and smoke. R2 was rolled onto her left side, placed a pillow underneath her back/buttocks area, covered with a blanket, and raised the head of the bed (HOB) approximately 40 degrees. NA-B and NA-E both removed their gloves, washed their hands, and exited the room. - at 10:45 a.m. R2 laid on back with HOB up to approximately 40 degrees awake. -at 11:15 a.m. R2 laid on back with HOB up to approximately 40 degrees eyes are closed. -at 12:00 p.m. LPN- B entered R2's room placed a small cup of supplement in front of her on the bedside table and exited the room. R2 laid on her back with HOB up to 40 degrees awake. -at 1:10 p.m., 1:46 p.m., 2:05 p.m., and 2:44 p.m., R2 laid in bed awake on her back positioned unchanged with HOB up to 40 degrees. -at 3:30 p.m. R2 laid in bed on her back awake positioned unchanged. R2 stated she had not been changed or repositioned since before lunch. During an interview on 10/26/22, at 3:50 p.m. RN-A verified she had not been made aware of R2's reddened area located on her coccyx. RN-A stated nursing staff are expected to complete weekly skin assessments on all residents on their bath day. RN-A indicated the last skin assessment completed on R2 was three weeks ago on 10/6/22, and there may have been a TMA	F 686			

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F 686	Continued From page 15 working the floor and nursing are expected to complete the skin assessments, and not sure why it was not done. RN-A nursing staff would leave a note under my door so I can see skin changes and ideally it would be documented in the progress notes. R3's quarterly MDS dated 7/20/22, identified moderately impaired cognition, diagnosis of peripheral vascular disease, and at risk for pressure ulcers. R3 required extensive assistance of one for personal hygiene, transfers, dressing, toileting use, and bed mobility, and continent of bowel and bladder. R3's care plan updated 6/28/22, listed various interventions which included assist of 1 with toileting, and transfers, monitor skin integrity daily during cares and weekly skin inspection by nurse, pressure redistribution mattress to bed and cushion to wheelchair, and monitor for skin breakdown for signs/symptoms of infection. R3's Braden scale dated10/18/22, moderate risk for skin breakdown. R3 was incontinent of bowel and bladder, wears incontinence briefs. R3 to be checked and changed every two hours. R3 was able to change positions in bed but may needed some cueing. Additionally, complete weekly skin checks. Review of R3's Weekly skin assessment dated 10/18/22, no new skin issues bruising still present from fall. No Weekly skin assessments documented on R3 from 8/18/22, through 10/17/22, and 10/19/22, through 10/26/22. R3's NAR care sheets provided the following information regarding transfers, bed mobility,	F 686			

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F 686	Continued From page 16 repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet. Last void 1:05 p.m. on day shift and over 7 ½ hours later 9:04 p.m. incontinent/BM. -on 10/24/22, night shift care sheet. Last void 9:04 p.m. Then three hours later at 12:05 p.m., 2:07 a.m., 4:05 a.m. incontinent all three times. The 4th round no check and change was documented. -on 10/25/22, day shift care sheet. Last void at 4:05 a.m. on night shift. Three hours later at 7:05 a.m. and 9:10 a.m. dry both times. At 11:45 a.m. and 1:00 p.m. incontinent. -on 10/25/22, evening shift care sheet. Last void at 1:00 p.m. on day shift and over 8 ½ hours later at 9:47 p.m. incontinent/BM. -on 10/25/22, night shift care sheet. Last void at 9:47 p.m. then at 12:06 a.m., 2:08 a.m., and 4:30 a.m. R3 was incontinent, and 4th round no check and change was documented. -on 10/26/22, day shift care sheet. Last void at 4:30 a.m. and 5 hours later at 9:30 a.m. bed change. -on 10/26/22, evening shift care sheet. Last void at 9:30 a.m. then 5 ½ hours later at 3:00 p.m. incontinent, 5:00 p.m. incontinent, and over 4 hours later at 9:52 p.m. incontinent. -on 10/26/22, night shift care sheet. Last void at 9:52 p.m. at 12:23 a.m. R3 refused, 3 ½ hours later at 1:40 a.m. incontinent, and 4th round no check and change documented. -on 10/27/22, day shift care sheet. Last void at 1:40 a.m. and over three hours later at 4:46 a.m. incontinent. R3's NAR care sheets lacked repositioning documentation. During observations/interviews on 10/25/22, from	F 686			

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F 686	Continued From page 17 9:15 a.m. to 1:00 p.m.: -at 9:15 a.m. R3 laid on left side with and legs hung over the side of the bed eating breakfast. -at 9:18 a.m., 9:57 a.m., 10:22 a.m., 10:30 a.m., 11:25 a.m., R3 laid in bed on her back, knees up, head of bed (HOB) up approximately 40 degrees and with lights off. -at 11:40 a.m. R3 laid in bed, knees up -at 12:15 p.m. R3 sat up in bed, leaned over and was observed picking up popcorn off the floor. NA-F entered R3's room with lunch on a tray. NA-F stated out loud "your bed is dirty, ugh"! NA-F also stated looks like we need to get in here and get you cleaned up for the day. NA-F suggested R3 eat lunch first then staff would help her after that. -at 12:37 p.m. during an interview R3 placed her call light on and stated she stayed in bed all day long and ate her meals her room also. R3 also stated staff come in to change her and it had been a while and that she needs help with that because she wears a brief and currently it was wet. -at 12:50p.m. NA-E entered R3's room and informed her she was going to get her cleaned up for the day. R3 requested surveyor leave room for privacy. -at 1:00 p.m. during an observation/interview NA-E opened R3's door carrying a bag of dirty linen and garbage. NA-E interviewed at that time and stated R3 used her call light "at times". NA-E also stated R3 had been incontinent of urine and an extra small bowel movement. NA-E verified R3 does not alert staff when she was wet and needed to be checked and changed every 2 hours. NA-E also verified R3's incontinent brief and lift sheet located directly underneath her was both soiled with urine/stool and had to be changed. NA-E stated it was a bit late today when	F 686			

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F 686	Continued From page 18 R3 got cleaned up but she likes to stay in bed and that she was not sure the last time she was checked on but it would most likely be on the nurse aide care sheet that staff fill out each shift. Review of NAR care sheet (above) indicated R3 was incontinent at 11:45 a.m. and presumably changed. This documentation is inconsistent with observation and interview, given R3 had soaked through both her incontinent brief and lift sheet when changed by NA-E at 12:50 p.m. During an interview on 10/26/22, at 3:50 p.m. RN-A verified R3's last weekly skin assessment was completed on 10/18/22, by myself. RN-A also verified no weekly assessments were completed on R3 from 8/18/22, through 10/17/22. RN-A stated there was documentation in the progress notes R3 refused to have skin assessment completed however, staff are expected to at least look at the resident's skin that is visible, check with NA when they plan on a check and change, and document a weekly skin assessment. R4's quarterly MDS dated 9/1/22, identified moderately impaired cognition and diagnosis of diabetes mellitus. R4 required extensive assistance of two with toileting and bed mobility and assistance of one for dressing, personal hygiene, and total dependence for transfers with assist of 2. Total dependence of 1 for locomotion on and off unit. R4's MDS also identified occasionally incontinent of bladder and always incontinent of bowel. R4 has two stage three pressure ulcers and is at risk for pressure ulcers and was currently taking a diuretic. R4's care plan updated 11/9/21, listed various interventions which included assist with movement in bed and in/out of bed, monitor skin	F 686			

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F 686	Continued From page 19 integrity daily during cares, and weekly skin inspection by nurse. Additionally, R4 required pressure redistribution mattress to bed and cushion to wheelchair, R4's Braden scale dated 9/1/22, identified R4 at mild risk for pressure ulcers. Review of R4's Weekly skin assessment last one completed 10/27/22, identified heel of foot wounds have healed. A little redness in groin area and slight pinkness to coccyx that is blanchable. Review of R4's Weekly skin assessment identified lack of evidence skin assessments were completed from 7/20/22 through 10/26/22. R4's NAR care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet 3:43 p.m. bed/TV, 5:15 p.m. dinner, 7:55 p.m. bed/TV, 9:30 p.m. emptied foley catheter. No documentation on repositioning. -on 10/26/22, day shift care sheet repositioned at 6:00 a.m., 9:13 a.m. bed, 10:40 a.m. foley catheter emptied, 1:30 p.m. bed. Repositioned once during the day shift. -on 10/26/22, evening shift care sheet 2:30 p.m. wheelchair, 5:05 p.m. refused supper, 6:45 p.m. clean up, and 9:00 p.m. emptied foley catheter. No documentation on repositioning. -on 10/26/22, night shift care sheet 12:10 a.m. repositioned/sleeping, 2:00 a.m. sleeping, and 4:00 a.m. emptied foley catheter, 4th round no documentation on care completed. Repositioned once during the night shift. -on 10/27/22, day shift care sheet 8:10 a.m. breakfast and 9:30 a.m. repositioned, 3rd and 4th	F 686			

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F 686	Continued From page 20 round no documentation on care completed. Repositioned once during the day shift. During an observation/interview on 10/26/22, at 10:20 a.m. R4 laid in bed on his back with HOB up to approximately 90 degrees. R4 stated he was unable to move himself around in bed and required the help of staff to reposition. R4 also stated staff come and help me reposition but not very often. At 10:30 a.m. NA-E entered R4's room, asked what he needed and shut off the call light. NA-E indicated he had repositioned R4 at 6:00 a.m. and NA-H came in after that to reposition him but would need to check the NAR sheets. NA-E stated he would let the nurse know R4 needed something for pain and exited the room. During observations on 10/26/22, at 11:00 a.m., 11:30 a.m., 12:00 p.m., 12:45 p.m., and 3:14 p.m. R4 remained on his back in bed with HOB up to approximately 90 degrees. R4 confirmed at 3:15 p.m. he had not been repositioned since this morning. During an interview on 10/27/22, at 10:30 a.m. RN-C stated R4 was unable to reposition and complete his own activities of daily living (ADLs) and required total assistance of two staff. RN-C indicated staff are expected to check and change and reposition R4 every two hours, it is common sense and important for dignity and prevention of skin breakdown. RN-C also stated R4 was able to use the call light but unaware of when he had to have a bowel movement. RN-C verified staff are expected to document when check and change and repositioning had been completed on the NAR care sheets. RN-C stated she does not normally review the NAR care sheets to see if	F 686			

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F 686	Continued From page 21 cares have been completed and staff should her know if there was a concern. RN-C also stated nursing staff are expected to complete weekly skin assessments on all residents on their bath day. RN-C verified R4 tends to refuse his bathes however nursing would still be expected to assess his skin and document it. RN-C indicated R4's last weekly skin assessment was completed today 10/27/22 and prior to that not since 7/20/22. RN-C verified there were weekly skin assessments that were not completed on R4 and should have been done even if R4 refused his bath. RN-C stated the weekly skin assessments are not being completed weekly, we are so busy, and the resident may refuse a bath and then we forget to go back and complete it. During an interview on 10/27/22, at 10:49 a.m. RN-B stated R4 required extensive assist of one with everything but eating, a Hoyer lift for transfers, and can move a little bit in bed but not a whole lot. Skin assessments are expected to be completed on each resident weekly. R4 had one completed today 10/27/22, however prior to that the last one was completed on 7/20/22. RN-B stated we are short staffed and the trained medication assistants (TMA) are on the medication carts and it is not easy not having enough staff. RN-B also stated the staff nurse was expected to complete the skin assessments on all residents on their bath day. RN-B indicated she had changed R4's brief and observed his skin frequently but did not document it. RN-B stated the wound nurse and the hospice nurse assess R4's skin but according to the documentation it had been a while. RN-B verified staff would be expected to reposition R4 every two to three hours to help prevent skin breakdown and document on the NAR sheets.	F 686			

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F 686	Continued From page 22 RN-B also indicated the staff floor nurse was expected to review the NAR sheets at the end of each shift to assure the residents were being toileted and repositioned. R5's quarterly MDS dated 4/22/22, identified severely impaired cognition and diagnosis of dementia. R5 required extensive assistance of one for personal hygiene, dressing, bed mobility, extensive assistance of two for toileting and transfers, and supervision of cuing and encouragement with locomotion on and off the unit. R5's MDS also identified always incontinent of bladder and frequently incontinent of bowel and at risk for pressure ulcers. R5's care plan updated 6/20/22, listed various interventions which included Hoyer lift for all transfers, provide assist with bed mobility to sit up, boost up and get feet in and out of bed, turn and reposition and offload every 2hours and as needed (PRN). Additionally, R5 required assist of 2 with toileting and transfers, extensive assist of 1 for hygiene and clothing adjustment, weekly skin audits with bath or shower, pressure redistribution mattress to bed and wheelchair, and assist with movement in bed. R5's Braden scale dated 10/26/22, identified moderate risk for skin breakdown. R5's Weekly skin assessment dated 10/24/22, identified no changes to skin. R5's NAR care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet last void at 11:50 a.m. over 7 hours at 7:45 p.m. incontinent,	F 686			

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F 686	Continued From page 23 and 9:16 p.m. incontinent. -on 10/24/22, night shift care sheet last void at 9:16 p.m., 12:23 a.m. incontinent, 2:23 a.m. incontinent, 4:20 a.m. incontinent, and 4th round no check and change was documented. -on 10/25/22, day shift care sheet last void at 4:20 a.m., over 2 1/2 hours at 7:15 a.m. incontinent, 3rd round no check and change was documented, and over 6 ½ hours at 2:00 p.m. incontinent. -on 10/25/22, evening shift care sheet last void at 2:00 p.m. over 4 ½ hours at 6:58 p.m. incontinent, and 9:12 p.m. incontinent. -on 10/25/22, night shift care sheet last void at 9:12 p.m., over 3 hours at 12:23 a.m. incontinent, 4:30 a.m. incontinent, and 4th round no check and change was documented. -on 10/26/22, day shift care sheet last void at 4:30 a.m. 6:00 a.m. 11:05 a.m. incontinent, and 12:50 p.m. incontinent. -on 10/26/22, evening shift care sheet last void at 12:50 p.m., over 6 hours at 7:10 p.m. incontinent, and 9:45 p.m. incontinent. -on 10/26/22, night shift care sheet last void at 9:45 p.m., over 2 hours at 12:07 a.m. incontinent, 2:10 a.m. incontinent, 4:20 a.m. incontinent. R5's NAR care sheets lacked repositioning documentation. During observations on 10/25/22, from 9:36 a.m. of R5 identified: -at 9:36 a.m. R5 sat in wheelchair in dining room next the window with her cloth protector still on from breakfast. -at 10:48 a.m. R5 sat in dining room still had clothing protector on from breakfast. R5 faced the window pulled, and folded panel curtain of windows.	F 686			

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F 686	Continued From page 24 -at 11:30 a.m. R5 is sat in dining room same position, location, and still had clothing protector on. -at 12:16 p.m. R5 ate lunch with assistance in dining room used same clothing protector from breakfast, no observation of R5 leaving dining area for check and change before lunch. -at 12:46 p.m. R5 still sitting in dining room appeared to be done eating and still drinking. -at 2:00 p.m. NA-B entered the dining room and asked R5 if she was ready to use the bathroom. NA-B pushed R5 in wheelchair out of dining room, down the hallway, and into the bath/toileting room. NA-B used the ceiling lift to transfer R5 from wheelchair to toilet. R5 was incontinent of urine and stool and incontinence product was observed to be saturated. While observing NA-B stated staff are assigned to a hallway and they work as a team to make sure all the residents are getting their check and changes completed. NA-B also stated staff use a nursing assistant record (NAR) sheet they sign off what has been completed. NA-B verified R5 sometimes used a call light but when she sat in the dining room would most likely would not have told a staff if she needed the bathroom. NA-B stated any of the staff that worked in this hallway would have been responsible to check and change R5 but would have to look at the NAR sheet to see who checked on her last and what time. Review of R5's NAR care sheet indicated she did not receive a check and change or offloading for 6 ½ hours before getting changed at 2 p.m. on 10/25/22. R5 was placed back in her wheelchair after her change. During an interview on 10/26/22, at 3:50 p.m.	F 686			

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F 686	Continued From page 25 RN-A stated R5 is at high risk for pressure ulcers and staff are expected to check and change and reposition her every 2 to 3 hours to help prevent skin problems. RN-A also stated R5 was able to make slight movements in bed but unable to lift herself off her bottom and required assistance with that. RN-A indicated R5 was unable to ask for help and staff were expected to anticipate her needs. During an interview on 10/26/22, at 10:31 a.m. NA-G stated there was a big issue with some staff not completing check and changes correctly or ensuring staff were providing adequate repositioning and offloading. NA-G indicated some residents were sitting in their urine and feces longer than appropriate. NA-G also stated this had been reported before and it was investigated but no real improvement was made. During an interview on 10/26/22, at 11:35 a.m. director of nursing (DON) stated if a resident was independent staff would be expected to have checked on them and identify what they did for them. DON also stated if a resident required assistance to remain continent and/or repositioning that should be identified on the NAR sheet with repo, and I/C (Incontinent/Continent). During an interview on 10/26/22, at 3:50 p.m. RN-A indicated staff are expected to document the residents needs such as when they were last toileted or checked and changed on the NAR sheets. RN-A indicated she expected the floor nurse to check the NAR sheets at the end of the shift to identify if the toileting is being completed. RN-A stated staff are expected to use the same codes to document on the NAR sheets such as D	F 686			

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F 686	Continued From page 26 for dry and I for incontinent. RN-A verified there had been many times staff had complained the documentation was not being done. RN-A indicated she was not sure how staff documented when a resident was repositioned. RN-A stated staff are not currently documenting repositioning. RN-A also stated it would be important to assure toileting, check and change, and repositioning was completed to help prevent too much pressure in areas and skin breakdown. Review of facility policy titled Skin Assessment & Wound Management revised 5/27/22, identified staff will perform routine skin inspections with daily care, notify the nurse if skin changes are identified, initiate weekly pressure wound evaluation, notify medical doctor (MD), treatment ordered, and care plan updated. A weekly skin inspection will be completed by licensed staff.	F 686			
F 692 SS=D	Repositioning policy was requested and not received. Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		12/2/22	

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F 692	Continued From page 27 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to offer sufficient fluid intake to maintain proper hydration and health for 3 of 4 (R2, R3, R5) reviewed for hydration. This had the potential to affect all 59 residents residing in the facility. Findings include: R2's quarterly minimum data set (MDS) dated 9/19/22, identified moderately impaired cognition. R2 required extensive assistance of one for personal hygiene, bed mobility, dressing, toilet use, independent with eating set up only, and total dependence with transfers. R2 also received a diuretic (water pill) daily. During an observation/interview on 10/25/22, at 10:45 a.m. R2 laid in bed and on bedside table was an empty sippy cup and mug with a cover on it. F2 stated the water that had been in her mug was from last night and she had not been drinking it. R2 also stated she wanted fresh water and staff had not offered her any when in the room. During an observation on 10/25/22, at 12:00 p.m. LPN-B entered R2's room with a small cup of supplement, placed it in front of R2 and next to her empty container of water. LPN-B did not	F 692	F692 Hydration Status Immediate Corrective Action: Resident 2, 3, and 5 were all provided fresh water. Corrective Action as it applies to others: Hydration Policy was reviewed and remains current. All residents will be provided clean mugs with fresh water except for those residents on fluid restrictions or requiring thickened liquids. All residents who require thickened liquids or have a fluid restriction will have a nursing order scheduled to MAR for nurse/TMA to provide thickened liquids of their choice QID or per their request. All CNAs will receive education to complete a fresh water/ice pass every shift except for those that don't have cups in their room d/t thickened liquids or residents on a fluid restriction. Date of Compliance: 12/2/22		

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F 692	Continued From page 28 offered water or fill the water container. During an observation/interview on 10/25/22, at 1:46 p.m. R2 laid awake on her back with head of bed up 45 degrees. R2's mug at bedside had a cover on it with approximately 100 ml of clear liquid in it and an empty sippy cup. R2 stated they still have not brought me fresh water and would really like some while she pointed at the empty cup with her right hand. R2 also stated she would like something more to drink and not sure why they are not able to bring fresh water. R2 indicated she had asked staff for fresh water this morning but had not received it. During an observation on 10/25/22, at 2:44 p.m. and 3:30 p.m. R2 laid in bed and did not have fresh water/liquids available to her and nothing reachable. During an interview/observation on 10/26/22, at 9:04 a.m. R2 sat in her wheelchair in her room. Located next to R2 on bedside table was a sippy cup with a cover and straw in it and approximately 2 ounces of brown liquid noted in it and a mug with a cover and straw in it with a small amount of water in the bottom of it. R2 stated my friend came by and brought me some root beer pop, placed it in that cup for me, and drank most of it maybe 6 ounces or so. R2 verified the water mug was the same as yesterday with only a small amount of water in it and had not been filled with fresh water for a couple of days by her friend. R2 stated I thought about asking about it when they brought fresh water in for my roommate yesterday, but they were cleaning me up. R2 also stated I wanted to say to them "what about me I would like some cold water too". R2 indicated when she asked for fresh water, they eventually	F 692	Recurrence will be prevented by: 5 residents will be audited to ensure that they have received fresh water/ice or hydration from nurse/TMA if on fluid restriction or thickened liquids. This will occur weekly x4 weeks then monthly times 2 months. The results of the audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audit. Corrections will be monitored by: Director of Nursing or Designee		

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F 692	Continued From page 29 bring it but keep forgetting. During observation on 10/26/22 at 10:41 a.m. the dietary staff was bringing water to resident on the unit. R2 was in her room and water was observed to be brough in for her roommate. No water was observed to be offered to R2. During observation and interview on 10/26/22 at 12:23 p.m. R2 was lying in bed, surveyor had asked if she would be having lunch and she said no, that she was not hungry. When asked if she had received any water yet, R2 stated she had not and she did not know why adding, the staff were in here and that her roommate got fresh water so she did not understand why she could not get some, but she would like some. During observation and interview on 10/26/22 at 3:01 p.m. R2 was still lying in bed and confirmed she did not have fresh water yet, mug and glass on bedside table still appeared to be untouched. Surveyor requested water from staff. During an observation on 10/27/22 at 11:28 a.m. located on R2's bedside table was a small amount of clear liquid approximately 100 millimeter (ml) in a covered mug, an empty sippy cup with a straw in it, and small glass half full thicken apple juice. No fresh water noted in R2's room. During an interview on 10/27/22, at 11:08 a.m. NA-C stated R2 does not care for honey thick liquids or thickened water, and maybe drinks 240 ml a shift with meals. NA-C also stated staff are expected to offer fluids to each resident when in their room to help prevent dehydration. NA-C stated R2 refused honey thickened liquids	F 692			

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F 692	Continued From page 30 frequently however staff were expected to offer R2 thicken liquids throughout the day. R3's quarterly MDS dated 7/20/22, identified moderately impaired cognition. R3 required extensive assistance of one for personal hygiene, transfers, dressing, toileting use, bed mobility, and independent with eating set up only. R3's physician orders dated 8/9/22, identified push fluids and monitor every shift During an observation on 10/25/22, at 9:18 a.m., 9:57 a.m., 10:30 a.m., 10:50 a.m., and 11:00 a.m. R3 laid on her back in bed, knees bent with head of bed up to 40 degrees. R3 had a full glass of thickened apple juice on her bedside table. No water available or observed in room. During an observation on 10/25/22, at 11:25 a.m. resident laid in bed on her back with knees bent. Only one-fourth of the thickened apple juice remained in the glass. No water available within reach. During an observation on 10/25/23, at 12:15 p.m. NA-F entered R3's room and placed her dinner tray on her bedside table. R3 had two glasses of thickened apple juice and no water. During an observation on 10/25/22, at 12:45 p.m. NA-E entered R3's room, asked her if she was still working on your lunch and R3 stated hardly. Two small glasses of thicken liquid were noted on the bedside table. One glass was three fourths full and the other one completely full. NA-E offered to leave the two small glasses of honey thick liquid apple juice but R3 refused and stated she had enough of that kind of stuff and was	F 692			

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F 692	Continued From page 31 getting tired of drinking it. No water was provided or offered at that time. During an interview/observation on 10/25/22, at 1:00 p.m. NA-E entered R3's room and she requested surveyor leave the room while NA-E completed a check and change. At 1:10 p.m. NA-E opened R3's room door. NA-E stated R2 was currently on a pureed and honey thick liquid diet and does not like thicken liquids. NA-E also stated R2 drank water every day and an assigned staff NA-D offered it daily to her and everyone in the facility but not sure why R2 did not have water in her room to drink today. NA-E completed the interview and did not provide or offer R3 water. During a telephone interview on 10/26/22, at 11:36 a.m. a family member (FM)-A stated [R3] loved to drink boost and does not get them anymore. FM-A indicated [R3] was not receiving enough fluids, loves water but does not like the thickening. FM-A also stated staff quit giving [R3] water since she had swallowing problems and aspirated in the hospital. FM-A verified it had been two months since she had seen water in her room and other than that pop was all she had been drinking. FM-A stated she had asked [R3] about receiving water and she indicted she been receiving water. R5's quarterly MDS dated 4/22/22, identified severely impaired cognition. R5 required extensive assistance of one for personal hygiene, dressing, bed mobility, extensive assistance of two for toileting and transfers, and supervision of cuing and encouragement with locomotion on and off the unit and eating. During an observation on 10/25/22, at 9:26 a.m.	F 692			

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F 692	Continued From page 32 R5 sat in wheelchair by window and still had clothing protector on from breakfast. During an observation on 10/25/22, at 10:48 a.m. R5 sat in wheelchair in dining room still had clothing protector on with milk and juice on table. R5 faced the window and pulled on the folding panel curtain blind. During an observation on 10/25/22, at 11:30 a.m. R5 sat in wheelchair in dining room in same position and location, still had clothing protector on and drinks on table had been removed. During and observation on 10/25/22, at 12:16 p.m. R5 ate lunch with assistance in dining room and had same clothing protector on as for breakfast. During a continuous observation on 10/25/22, from 1:30 p.m. to 2:00 p.m. R5 sat in wheelchair awake by the window in the dining room: -at 1:41 p.m. nurse assistant (NA)-A entered the dining room, approached an unidentified resident, asked if interested in attending activities, then pushed resident in wheelchair out of the dining room and down the hallway. No fluids offered to R5 during this observation. -at 1:48 pm NA-B entered the dining room said hello to R5, exited the room, walked down the hallway, and entered another resident's room. No fluids offered to R5 during this observation. -a 1:52 p.m. licensed practical nurse (LPN)-B entered the dining room, grabbed juice out of the refrigerator, glanced over at R5, walked out of the room while she held the containers and stated, "I need to get stocked for the evening shift". No fluids offered to R5 during this observation.	F 692			

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F 692	Continued From page 33 Observation 10/26/22 at 2:00 p.m. R2 was taken to bathroom for check and change. She was lifted back into her wheelchair and pushed back into the dining room. No fresh water was offered. During an interview on 10/26/22, at 3:50 p.m. RN-A stated NA-D was expected to pass fresh water to the residents during the day shift. RN-A indicated all residents should receive water unless they are on a special diet then they would have received thicken water, and maybe a smaller portion. RN-A stated it would be important to provide fresh water to all residents to help prevent dehydration. During an interview on 10/27/22, at 8:31 a.m. dietary manager (DM) stated nursing staff are expected to pass fresh water at least twice a day usually between breakfast and lunch and also between lunch and supper. DM also stated fresh water was expected to be given to all residents cleared to drink regular liquids. DM indicated residents on special diets are usually ones that do not have the initiative to drink on their own and therefore staff are expected to offer water during medication past time, during cares, and whenever in the resident's room to keep their fluids up and hydrated. During an interview on 10/27/22, at 10:30 am RN-C stated NA-D was assigned to pass fresh water to all residents but not sure how often. RN-C also stated those residents on a special diet such as nectar thicken liquid should have received thicken water. RN-C indicated residents become dehydrated, which can be very serious, and end up in the hospital very quickly.	F 692			

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F 692	Continued From page 34 During an interview on 10/27/22, at 11:50 a.m. the director of nursing (DON) stated the nursing assistants and the direct care staff are expected to provide fresh water once a day every day and offer water to each resident during completion of cares, assisting residents, and during rounds. DON verified staff are also expected to offer thicken fresh water to the residents on special diets. DON stated residents are at risk for hydration problems and fresh water helped prevent dehydration. Review of facility policy titled Hydration revised 9/2012, identified the facility will provide adequate hydration to each resident to achieve and maintain overall health status by taking into consideration each resident's underlying disease state, mental and physical limitations; unless the resident's clinical condition indicates that a decline is unavoidable. Dehydration in the elderly has long been considered a significant health problem which can lead to increased morbidity and mortality, and costly medical care. The following are risk factors for dehydration: inability to obtain water freely, due to any number of conditions such as stroke, impaired movement, impaired cognition, and impaired communication.	F 692			
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.	F 880		12/2/22	

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F 880	Continued From page 35 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the 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	F 880			

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F 880	Continued From page 36 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper sanitization of shared glucose meter (device to test blood sugar levels) for 1 of 1 resident (R7) when observed use for shared medical equipment. Findings include: R7's quarterly minimum data set (MDS) dated 9/29/22, identified R7 intact cognition, extensive assistant with all activities of daily living, transfers, and medical diagnoses of diabetes mellitus (DM). R7's electronic medication administration record (EMAR), 10/26/22, at 11:01 a.m. identified a blood glucose level of 148 milligrams/deciliter (mg/dl) had been completed by licensed practical nurse (LPN)-A.	F 880	F880 Infection Prevention and Control Immediate Corrective Action: Resident 7 received their own glucometer to keep him his room for individualized use by nurse. Corrective Action as it applies to others: Obtaining a Finger Stick Glucose Level Policy was reviewed and remains current. All residents who require blood glucose monitoring were provided a glucometer for their room for their own individualized use. All nurses will receive education regarding utilizing the resident's glucometer that is kept in their room for all of the resident's blood sugar checks and not to "share" glucometers between residents.		

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F 880	Continued From page 37 During an observation on 10/26/22, at 11:00 a.m. LPN-A exited R7's room, held a square plastic container in her right hand containing a glucose meter positioned on top of alcohol swabs, gaze pads, lancets, and a container of glucose test strips. LPN-A placed the container on top of the medication cart, sanitized her hands, logged onto computer, and documented R7's blood glucose level. At 11:10 a.m. LPN-A locked medication cart and computer screen and walked down the hallway. During an interview on 10/26/22, at 11:10 a.m. LPN-A verified she had used the glucose meter taken from on top of the medication cart and checked R7's glucose level. LPN-A stated she had not disinfected/cleansed the glucose meter, was here all day working, and no one else will use it. LPN-A identified the dirty glucose meter laid on top of the supplies located in the square plastic container. LPN-A stated R7 had her own glucose meter in her room and grabbed the one on top of the medication cart instead, brought it into her room, and checked a blood glucose level. LPN-A identified nursing staff are expected to disinfect the glucose meter prior to placing back into the container with the supplies to help prevent spread of germs. LPN-A stated the glucose meter was an extra one and would mostly likely not be used on other residents but possibly could be used on a resident that was crashing or a newly admitted diabetic. During an interview on 10/26/22, at 3:50 p.m. registered nurse (RN)-A stated nursing staff are expected to use the glucose meter provided for each diabetic resident located in their room. RN-A indicted the glucose meter located on the medication cart should not be used on any	F 880	The DON, Infection Preventionist, and Designee will conduct return demonstration competencies with nurses on how to properly sanitize glucometers before and after use if they are not utilizing the resident's own glucometer in room. Date of Compliance: 12/2/22 Recurrence will be prevented by: The DON, Infection Preventionist and other leadership staff will conduct audits on all shifts, every day for one week to assure that staff are properly sanitizing glucometers before and after use if staff are not utilizing the resident's own glucometer in room. The results of the audits will be shared with the facility QAPI Committee and based on the results, the audits will continue daily or decrease in numbers and be discontinued once 100% compliance is demonstrated. Corrections will be monitored by: Director of Nursing or Designee		

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F 880	Continued From page 38 residents. RN-A verified community blood sugar monitoring should not be going around and completed with the same glucose meter. RN-A also stated the glucose meter should be cleaned off with sanitizing wipes before and after use and should not be placed on top of supplies until cleansed. During an interview on 10/27/22, at 10:49 a.m. RN-B stated all diabetic residents should have their own glucose meter in their room. RN-B also stated she was not sure why two extra glucose meters were kept on the medication carts but maybe would be used after a fall and a glucose level needed to be checked. RN-B stated the glucose meter could be used on multiple residents only if it had been cleaned and disinfected properly. RN-B also stated we want to avoid transmission of germs from hands, from one resident to another, and for infection control. During an interview on 10/27/22, at 11:50 p.m. with director of nursing (DON) stated each diabetic resident has their own glucose meter and should not be used on multiple residents due to risk of infection. DON also stated the extra glucose meter on the medication cart was used in case another one quite working. DON indicated staff would be expected to sanitize the glucose meter before and after use and prior to placing it back into the medication cart to help prevent infection. Review of facility policy titled Obtaining a Finger Stick Glucose Level dated 2001, identified always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Clean and disinfect reusable equipment between uses according to the	F 880			

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F 880	Continued From page 39 manufacturer's instructions and current infection control standards of practice. Review of the manufacturer's instructions titled Assure Prism Multi blood glucose monitoring system dated 2020, identified to minimize the risk of transmitting blood borne pathogens, the cleaning and disinfection procedure should be performed after use on each patient. The Assure Prism Multi-Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure with the first wipe and disinfecting procedure is needed to prevent the transmission of blood borne pathogens with a second wipe. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood-borne pathogens.	F 880			

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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/25/22 to 10/27/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be 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	2 000		

Minnesota Department of Health		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/23/22

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2 000	Continued From page 1 be completed The following complaints were found to be SUBSTANTIATED: H52775141C (H00087658), H52775356C (MN00087659), H52775142C (MN00087657), with licensing orders issued at 905, 920, 940, and 1385. 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 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	2 000		

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2 000	Continued From page 2 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		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was offered and weekly skin assessments completed for 4 of 5 residents (R2, R3, R4, R5,) reviewed who were at risk for development of pressure ulcers. Findings include: R2's quarterly minimum data set (MDS) dated 9/19/22, identified moderately impaired cognition and diagnoses of diabetes mellitus, hemiplegia (weakness on one side), and at risk for pressure ulcers. R2 required extensive assistance of one	2 905	Corrected	12/2/22

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2 905	Continued From page 3 for personal hygiene, bed mobility, dressing, toilet use, and total dependence with transfers. R2 also received an anticoagulant and diuretic (water pill) daily and always incontinent of bowel and bladder. R2's care plan dated 3/15/22, listed various interventions which included monitor skin integrity daily during cares, weekly skin inspection by nurse, turn and reposition or reminders to offload every 2 to 3 hours and as needed, pressure redistribution mattress to bed and wheelchair. Additionally, R2 required assist with movement in bed and in/out of bed and assist of 1 with toileting. R2's Braden scale (tool used to determine pressure ulcer risk) dated 9/19/22, identified mild risk for skin breakdown, very limited mobility, and potential for a problem with friction and shear, was chairfast, alert and oriented with confusion, and could not always communicate discomfort or need to be turned. Staff were expected to check and change R2 and provide reminders for repositioning and offloading every 2 hours and PRN. Weekly skin checks to be completed on R2 and notify licensed nurse of any noted skin changes. Review of R2's Weekly skin inspection dated 10/6/22, identified no changes to skin. The skin assessment document also indicated it was the nurses responsibility to evaluate the residents skin at minimum once a week to ensure skin integrity and implement interventions as applicable. There was no evidence of weekly skin assessments were completed after 10/6/22. Review of R2's nursing assistant report (NAR) care sheets 10/24/22 through 10/26/22, provided	2 905		

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2 905	Continued From page 4 the following information regarding transfers, bed mobility, repositioning, toileting, and eating: R2's nursing assistant record (NAR) care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet last void 11:00 a.m., 8 hours later at 9:00 p.m. documented as incontinent. -on 10/24/22, night shift care sheet last void at 9:00 p.m., 3 hours later at 12:00 a.m. incontinent, 4:00 a.m. incontinent, and 4th round no documentation for check and change. -on 10/25/22, day shift care sheet last void 4:00 a.m., over 4 hours later at 8:15 a.m. incontinent, 10:15 a.m., and 4th round no documentation for check and change. -on 10/25/22, evening shift care sheet last void 8:15 a.m. over 6 ½ hours at 2:56 p.m. incontinent, and over 6 hours later at 8:55 p.m. incontinent. -on 10/25/22, night shift care sheet last void 8:55 p.m. over 4 hours later at 12:06 a.m. incontinent/BM, 2:08 a.m. and 4:36 a.m. both times incontinent. -on 10/26/22, day shift care sheet last void at 4:20 a.m. at 7:17 a.m. dry, 8:20 a.m. repositioned, 10:41 a.m. incontinent and 1:00 p.m. dry. -on 10/26/22, evening shift care sheet last void at 10:41 a.m., over 3 ½ hours later at 2:40 p.m. incontinent, over 3 hours later at 6:13 p.m. incontinent, and again at 3 hours later at 9:53 p.m. dry. -on 10/26/22, night shift care sheet last void at 6:13 p.m., over 6 hours later at 12:20 a.m. incontinent, 1:36 a.m. dry, 3:00 a.m. incontinent, and 4th round no documentation of check and change. R2's NAR care sheets lacked repositioning	2 905		

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2 905	Continued From page 5 documentation. During intermittent observations on 10/25/22, R2 laid in bed from 10:33 a.m. to 3:30 p.m. (confirmed by documentation): -at 10:33 a.m. NA-B and NA-E entered R2's room, placed lift sheet underneath R2 and transferred her from wheelchair to the bed. NA-E asked R2 if her brief was wet and R2 stated no. NA-B checked the brief and it was wet. NA-B asked R2 if they could change her brief and she stated yes. NA-B pulled R2's pants down to her knees and pulled back the brief wet with urine and tucked it between her legs. NA-B wiped from front to back with moistened wipe. R2's labia was slightly red. NA-B applied a barrier cream to the outer side of the labia with gloves on. NA-E rolled R2 onto her left side and identified a red area on R2's coccyx and verified it measured approximately 4 inches long by ½ inch wide. NA-B applied barrier cream to coccyx area and also verified there were no open areas noted. NA-B stated he had already informed the staff nurse about the red area on R2's coccyx. NA-B stated R2 liked to sit up in her wheelchair and go out and smoke. R2 was rolled onto her left side, placed a pillow underneath her back/buttocks area, covered with a blanket, and raised the head of the bed (HOB) approximately 40 degrees. NA-B and NA-E both removed their gloves, washed their hands, and exited the room. - at 10:45 a.m. R2 laid on back with HOB up to approximately 40 degrees awake. -at 11:15 a.m. R2 laid on back with HOB up to approximately 40 degrees eyes are closed. -at 12:00 p.m. LPN- B entered R2's room placed	2 905		

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2 905	Continued From page 6 a small cup of supplement in front of her on the bedside table and exited the room. R2 laid on her back with HOB up to 40 degrees awake. -at 1:10 p.m., 1:46 p.m., 2:05 p.m., and 2:44 p.m., R2 laid in bed awake on her back positioned unchanged with HOB up to 40 degrees. -at 3:30 p.m. R2 laid in bed on her back awake positioned unchanged. R2 stated she had not been changed or repositioned since before lunch. During an interview on 10/26/22, at 3:50 p.m. RN-A verified she had not been made aware of R2's reddened area located on her coccyx. RN-A stated nursing staff are expected to complete weekly skin assessments on all residents on their bath day. RN-A indicated the last skin assessment completed on R2 was three weeks ago on 10/6/22, and there may have been a TMA working the floor and nursing are expected to complete the skin assessments, and not sure why it was not done. RN-A nursing staff would leave a note under my door so I can see skin changes and ideally it would be documented in the progress notes. R3's quarterly MDS dated 7/20/22, identified moderately impaired cognition, diagnosis of peripheral vascular disease, and at risk for pressure ulcers. R3 required extensive assistance of one for personal hygiene, transfers, dressing, toileting use, and bed mobility, and continent of bowel and bladder. R3's care plan updated 6/28/22, listed various interventions which included assist of 1 with toileting, and transfers, monitor skin integrity daily during cares and weekly skin inspection by nurse, pressure redistribution mattress to bed and	2 905		

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2 905	Continued From page 7 cushion to wheelchair, and monitor for skin breakdown for signs/symptoms of infection. R3's Braden scale dated 10/18/22, moderate risk for skin breakdown. R3 was incontinent of bowel and bladder, wears incontinence briefs. R3 to be checked and changed every two hours. R3 was able to change positions in bed but may needed some cueing. Additionally, complete weekly skin checks. Review of R3's Weekly skin assessment dated 10/18/22, no new skin issues bruising still present from fall. No Weekly skin assessments documented on R3 from 8/18/22, through 10/17/22, and 10/19/22, through 10/26/22. R3's NAR care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet. Last void 1:05 p.m. on day shift and over 7 ½ hours later 9:04 p.m. incontinent/BM. -on 10/24/22, night shift care sheet. Last void 9:04 p.m. Then three hours later at 12:05 p.m., 2:07 a.m., 4:05 a.m. incontinent all three times. The 4th round no check and change was documented. -on 10/25/22, day shift care sheet. Last void at 4:05 a.m. on night shift. Three hours later at 7:05 a.m. and 9:10 a.m. dry both times. At 11:45 a.m. and 1:00 p.m. incontinent. -on 10/25/22, evening shift care sheet. Last void at 1:00 p.m. on day shift and over 8 ½ hours later at 9:47 p.m. incontinent/BM. -on 10/25/22, night shift care sheet. Last void at 9:47 p.m. then at 12:06 a.m., 2:08 a.m., and 4:30 a.m. R3 was incontinent, and 4th round no check and change was documented. -on 10/26/22, day shift care sheet. Last void at	2 905		

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2 905	Continued From page 8 4:30 a.m. and 5 hours later at 9:30 a.m. bed change. -on 10/26/22, evening shift care sheet. Last void at 9:30 a.m. then 5 ½ hours later at 3:00 p.m. incontinent, 5:00 p.m. incontinent, and over 4 hours later at 9:52 p.m. incontinent. -on 10/26/22, night shift care sheet. Last void at 9:52 p.m. at 12:23 a.m. R3 refused, 3 ½ hours later at 1:40 a.m. incontinent, and 4th round no check and change documented. -on 10/27/22, day shift care sheet. Last void at 1:40 a.m. and over three hours later at 4:46 a.m. incontinent. R3's NAR care sheets lacked repositioning documentation. During observations/interviews on 10/25/22, from 9:15 a.m. to 1:00 p.m.: -at 9:15 a.m. R3 laid on left side with and legs hung over the side of the bed eating breakfast. -at 9:18 a.m., 9:57 a.m., 10:22 a.m., 10:30 a.m., 11:25 a.m., R3 laid in bed on her back, knees up, head of bed (HOB) up approximately 40 degrees and with lights off. -at 11:40 a.m. R3 laid in bed, knees up -at 12:15 p.m. R3 sat up in bed, leaned over and was observed picking up popcorn off the floor. NA-F entered R3's room with lunch on a tray. NA-F stated out loud "your bed is dirty, ugh"! NA-F also stated looks like we need to get in here and get you cleaned up for the day. NA-F suggested R3 eat lunch first then staff would help her after that. -at 12:37 p.m. during an interview R3 placed her call light on and stated she stayed in bed all day long and ate her meals her room also. R3 also stated staff come in to change her and it had been a while and that she needs help with that because she wears a brief and currently it was	2 905		

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2 905	Continued From page 9 wet. -at 12:50p.m. NA-E entered R3's room and informed her she was going to get her cleaned up for the day. R3 requested surveyor leave room for privacy. -at 1:00 p.m. during an observation/interview NA-E opened R3's door carrying a bag of dirty linen and garbage. NA-E interviewed at that time and stated R3 used her call light "at times". NA-E also stated R3 had been incontinent of urine and an extra small bowel movement. NA-E verified R3 does not alert staff when she was wet and needed to be checked and changed every 2 hours. NA-E also verified R3's incontinent brief and lift sheet located directly underneath her was both soiled with urine/stool and had to be changed. NA-E stated it was a bit late today when R3 got cleaned up but she likes to stay in bed and that she was not sure the last time she was checked on but it would most likely be on the nurse aide care sheet that staff fill out each shift. Review of NAR care sheet (above) indicated R3 was incontinent at 11:45 a.m. and presumably changed. This documentation is inconsistent with observation and interview, given R3 had soaked through both her incontinent brief and lift sheet when changed by NA-E at 12:50 p.m. During an interview on 10/26/22, at 3:50 p.m. RN-A verified R3's last weekly skin assessment was completed on 10/18/22, by myself. RN-A also verified no weekly assessments were completed on R3 from 8/18/22, through 10/17/22. RN-A stated there was documentation in the progress notes R3 refused to have skin assessment completed however, staff are expected to at least look at the resident's skin that is visible, check with NA when they plan on a check and change, and document a weekly skin assessment.	2 905		

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2 905	Continued From page 10 R4's quarterly MDS dated 9/1/22, identified moderately impaired cognition and diagnosis of diabetes mellitus. R4 required extensive assistance of two with toileting and bed mobility and assistance of one for dressing, personal hygiene, and total dependence for transfers with assist of 2. Total dependence of 1 for locomotion on and off unit. R4's MDS also identified occasionally incontinent of bladder and always incontinent of bowel. R4 has two stage three pressure ulcers and is at risk for pressure ulcers and was currently taking a diuretic. R4's care plan updated 11/9/21, listed various interventions which included assist with movement in bed and in/out of bed, monitor skin integrity daily during cares, and weekly skin inspection by nurse. Additionally, R4 required pressure redistribution mattress to bed and cushion to wheelchair, R4's Braden scale dated 9/1/22, identified R4 at mild risk for pressure ulcers. Review of R4's Weekly skin assessment last one completed 10/27/22, identified heel of foot wounds have healed. A little redness in groin area and slight pinkness to coccyx that is blanchable. Review of R4's Weekly skin assessment identified lack of evidence skin assessments were completed from 7/20/22 through 10/26/22. R4's NAR care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet 3:43 p.m. bed/TV, 5:15 p.m. dinner, 7:55 p.m. bed/TV, 9:30 p.m. emptied foley catheter. No documentation on repositioning.	2 905		

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2 905	Continued From page 11 -on 10/26/22, day shift care sheet repositioned at 6:00 a.m., 9:13 a.m. bed, 10:40 a.m. foley catheter emptied, 1:30 p.m. bed. Repositioned once during the day shift. -on 10/26/22, evening shift care sheet 2:30 p.m. wheelchair, 5:05 p.m. refused supper, 6:45 p.m. clean up, and 9:00 p.m. emptied foley catheter. No documentation on repositioning. -on 10/26/22, night shift care sheet 12:10 a.m. repositioned/sleeping, 2:00 a.m. sleeping, and 4:00 a.m. emptied foley catheter, 4th round no documentation on care completed. Repositioned once during the night shift. -on 10/27/22, day shift care sheet 8:10 a.m. breakfast and 9:30 a.m. repositioned, 3rd and 4th round no documentation on care completed. Repositioned once during the day shift. During an observation/interview on 10/26/22, at 10:20 a.m. R4 laid in bed on his back with HOB up to approximately 90 degrees. R4 stated he was unable to move himself around in bed and required the help of staff to reposition. R4 also stated staff come and help me reposition but not very often. At 10:30 a.m. NA-E entered R4's room, asked what he needed and shut off the call light. NA-E indicated he had repositioned R4 at 6:00 a.m. and NA-H came in after that to reposition him but would need to check the NAR sheets. NA-E stated he would let the nurse know R4 needed something for pain and exited the room. During observations on 10/26/22, at 11:00 a.m., 11:30 a.m., 12:00 p.m., 12:45 p.m., and 3:14 p.m. R4 remained on his back in bed with HOB up to approximately 90 degrees. R4 confirmed at 3:15 p.m. he had not been repositioned since this morning.	2 905		

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2 905	Continued From page 12 During an interview on 10/27/22, at 10:30 a.m. RN-C stated R4 was unable to reposition and complete his own activities of daily living (ADLs) and required total assistance of two staff. RN-C indicated staff are expected to check and change and reposition R4 every two hours, it is common sense and important for dignity and prevention of skin breakdown. RN-C also stated R4 was able to use the call light but unaware of when he had to have a bowel movement. RN-C verified staff are expected to document when check and change and repositioning had been completed on the NAR care sheets. RN-C stated she does not normally review the NAR care sheets to see if cares have been completed and staff should her know if there was a concern. RN-C also stated nursing staff are expected to complete weekly skin assessments on all residents on their bath day. RN-C verified R4 tends to refuse his bathes however nursing would still be expected to assess his skin and document it. RN-C indicated R4's last weekly skin assessment was completed today 10/27/22 and prior to that not since 7/20/22. RN-C verified there were weekly skin assessments that were not completed on R4 and should have been done even if R4 refused his bath. RN-C stated the weekly skin assessments are not being completed weekly, we are so busy, and the resident may refuse a bath and then we forget to go back and complete it. During an interview on 10/27/22, at 10:49 a.m. RN-B stated R4 required extensive assist of one with everything but eating, a Hoyer lift for transfers, and can move a little bit in bed but not a whole lot. Skin assessments are expected to be completed on each resident weekly. R4 had one completed today 10/27/22, however prior to that the last one was completed on 7/20/22. RN-B stated we are short staffed and the trained	2 905		

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2 905	Continued From page 13 medication assistants (TMA) are on the medication carts and it is not easy not having enough staff. RN-B also stated the staff nurse was expected to complete the skin assessments on all residents on their bath day. RN-B indicated she had changed R4's brief and observed his skin frequently but did not document it. RN-B stated the wound nurse and the hospice nurse assess R4's skin but according to the documentation it had been a while. RN-B verified staff would be expected to reposition R4 every two to three hours to help prevent skin breakdown and document on the NAR sheets. RN-B also indicated the staff floor nurse was expected to review the NAR sheets at the end of each shift to assure the residents were being toileted and repositioned. R5's quarterly MDS dated 4/22/22, identified severely impaired cognition and diagnosis of dementia. R5 required extensive assistance of one for personal hygiene, dressing, bed mobility, extensive assistance of two for toileting and transfers, and supervision of cuing and encouragement with locomotion on and off the unit. R5's MDS also identified always incontinent of bladder and frequently incontinent of bowel and at risk for pressure ulcers. R5's care plan updated 6/20/22, listed various interventions which included Hoyer lift for all transfers, provide assist with bed mobility to sit up, boost up and get feet in and out of bed, turn and reposition and offload every 2hours and as needed (PRN). Additionally, R5 required assist of 2 with toileting and transfers, extensive assist of 1 for hygiene and clothing adjustment, weekly skin audits with bath or shower, pressure redistribution mattress to bed and wheelchair, and assist with movement in bed.	2 905		

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2 905	Continued From page 14 R5's Braden scale dated 10/26/22, identified moderate risk for skin breakdown. R5's Weekly skin assessment dated 10/24/22, identified no changes to skin. R5's NAR care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet last void at 11:50 a.m. over 7 hours at 7:45 p.m. incontinent, and 9:16 p.m. incontinent. -on 10/24/22, night shift care sheet last void at 9:16 p.m., 12:23 a.m. incontinent, 2:23 a.m. incontinent, 4:20 a.m. incontinent, and 4th round no check and change was documented. -on 10/25/22, day shift care sheet last void at 4:20 a.m., over 2 1/2 hours at 7:15 a.m. incontinent, 3rd round no check and change was documented, and over 6 1/2 hours at 2:00 p.m. incontinent. -on 10/25/22, evening shift care sheet last void at 2:00 p.m. over 4 1/2 hours at 6:58 p.m. incontinent, and 9:12 p.m. incontinent. -on 10/25/22, night shift care sheet last void at 9:12 p.m., over 3 hours at 12:23 a.m. incontinent, 4:30 a.m. incontinent, and 4th round no check and change was documented. -on 10/26/22, day shift care sheet last void at 4:30 a.m. 6:00 a.m. 11:05 a.m. incontinent, and 12:50 p.m. incontinent. -on 10/26/22, evening shift care sheet last void at 12:50 p.m., over 6 hours at 7:10 p.m. incontinent, and 9:45 p.m. incontinent. -on 10/26/22, night shift care sheet last void at 9:45 p.m., over 2 hours at 12:07 a.m. incontinent, 2:10 a.m. incontinent, 4:20 a.m. incontinent. R5's NAR care sheets lacked repositioning	2 905		

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2 905	Continued From page 15 documentation. During observations on 10/25/22, from 9:36 a.m. of R5 identified: -at 9:36 a.m. R5 sat in wheelchair in dining room next the window with her cloth protector still on from breakfast. -at 10:48 a.m. R5 sat in dining room still had clothing protector on from breakfast. R5 faced the window pulled, and folded panel curtain of windows. -at 11:30 a.m. R5 is sat in dining room same position, location, and still had clothing protector on. -at 12:16 p.m. R5 ate lunch with assistance in dining room used same clothing protector from breakfast, no observation of R5 leaving dining area for check and change before lunch. -at 12:46 p.m. R5 still sitting in dining room appeared to be done eating and still drinking. -at 2:00 p.m. NA-B entered the dining room and asked R5 if she was ready to use the bathroom. NA-B pushed R5 in wheelchair out of dining room, down the hallway, and into the bath/toileting room. NA-B used the ceiling lift to transfer R5 from wheelchair to toilet. R5 was incontinent of urine and stool and incontinence product was observed to be saturated. While observing NA-B stated staff are assigned to a hallway and they work as a team to make sure all the residents are getting their check and changes completed. NA-B also stated staff use a nursing assistant record (NAR) sheet they sign off what has been completed. NA-B verified R5 sometimes used a call light but when she sat in the dining room would most likely would not have told a staff if she needed the bathroom. NA-B stated any of the staff that worked in this hallway would have been responsible to check and change R5 but would have to look at the NAR	2 905		

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2 905	Continued From page 16 sheet to see who checked on her last and what time. Review of R5's NAR care sheet indicated she did not receive a check and change or offloading for 6 ½ hours before getting changed at 2 p.m. on 10/25/22. R5 was placed back in her wheelchair after her change. During an interview on 10/26/22, at 3:50 p.m. RN-A stated R5 is at high risk for pressure ulcers and staff are expected to check and change and reposition her every 2 to 3 hours to help prevent skin problems. RN-A also stated R5 was able to make slight movements in bed but unable to lift herself off her bottom and required assistance with that. RN-A indicated R5 was unable to ask for help and staff were expected to anticipate her needs. During an interview on 10/26/22, at 10:31 a.m. NA-G stated there was a big issue with some staff not completing check and changes correctly or ensuring staff were providing adequate repositioning and offloading. NA-G indicated some residents were sitting in their urine and feces longer than appropriate. NA-G also stated this had been reported before and it was investigated but no real improvement was made. During an interview on 10/26/22, at 11:35 a.m. director of nursing (DON) stated if a resident was independent staff would be expected to have checked on them and identify what they did for them. DON also stated if a resident required assistance to remain continent and/or repositioning that should be identified on the NAR sheet with repo, and I/C (Incontinent/Continent).	2 905		

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2 905	Continued From page 17 During an interview on 10/26/22, at 3:50 p.m. RN-A indicated staff are expected to document the residents needs such as when they were last toileted or checked and changed on the NAR sheets. RN-A indicated she expected the floor nurse to check the NAR sheets at the end of the shift to identify if the toileting is being completed. RN-A stated staff are expected to use the same codes to document on the NAR sheets such as D for dry and I for incontinent. RN-A verified there had been many times staff had complained the documentation was not being done. RN-A indicated she was not sure how staff documented when a resident was repositioned. RN-A stated staff are not currently documenting repositioning. RN-A also stated it would be important to assure toileting, check and change, and repositioning was completed to help prevent too much pressure in areas and skin breakdown. Review of facility policy titled Skin Assessment & Wound Management revised 5/27/22, identified staff will perform routine skin inspections with daily care, notify the nurse if skin changes are identified, initiate weekly pressure wound evaluation, notify medical doctor (MD), treatment ordered, and care plan updated. A weekly skin inspection will be completed by licensed staff. Repositioning policy was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding care of the resident identified for risk for skin breakdown. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.	2 905		

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2 905	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance and incontinence care for 3 of 3 residents (R2, R3, R5) who were dependent upon staff for care. Findings include: R2's quarterly minimum data set (MDS) dated 9/19/22, identified moderately impaired cognition and diagnoses of diabetes mellitus (DM), hemiplegia (weakness on one side), and at risk for pressure ulcers. R2 required extensive assistance of one for personal hygiene, bed mobility, dressing, toilet use, and total dependence with transfers. R2 also received an anticoagulant and diuretic (water pill) daily and always incontinent of bowel and bladder. R2's care plan dated 3/15/22, listed various interventions which included turn and reposition or reminders to offload every 2 to 3 hours and as needed, required assist with movement in bed	2 920	Corrected	12/2/22

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2 920	Continued From page 19 and in/out of bed and assist of 1 with toileting. R2's Braden scale (tool used to determine pressure ulcer risk) dated 9/19/22, identified mild risk for skin breakdown, very limited mobility, and potential for a problem with friction and shear, was chairfast, alert and oriented with confusion, and could not always communicate discomfort or need to be turned. directed staff were expected to check and change R2 and provide reminders for repositioning and offloading every 2 hours and PRN. R2's nursing assistant record (NAR) care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet last void 11:00 a.m., 8 hours later at 9:00 p.m. documented as incontinent. -on 10/24/22, night shift care sheet last void at 9:00 p.m., 3 hours later at 12:00 a.m. incontinent, 4:00 a.m. incontinent, and 4th round no documentation for check and change. -on 10/25/22, day shift care sheet last void 4:00 a.m., over 4 hours later at 8:15 a.m. incontinent, 10:15 a.m., and 4th round no documentation for check and change. -on 10/25/22, evening shift care sheet last void 8:15 a.m. over 6 ½ hours at 2:56 p.m. incontinent, and over 6 hours later at 8:55 p.m. incontinent. -on 10/25/22, night shift care sheet last void 8:55 p.m. over 4 hours later at 12:06 a.m. incontinent/BM, 2:08 a.m. and 4:36 a.m. both times incontinent. -on 10/26/22, day shift care sheet last void at 4:20 a.m. at 7:17 a.m. dry, 8:20 a.m. repositioned, 10:41 a.m. incontinent and 1:00 p.m. dry. -on 10/26/22, evening shift care sheet last void at 10:41 a.m., over 3 ½ hours later at 2:40 p.m.	2 920		

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2 920	Continued From page 20 incontinent, over 3 hours later at 6:13 p.m. incontinent, and again at 3 hours later at 9:53 p.m. dry. -on 10/26/22, night shift care sheet last void at 6:13 p.m., over 6 hours later at 12:20 a.m. incontinent, 1:36 a.m. dry, 3:00 a.m. incontinent, and 4th round no documentation of check and change. During an observation on 10/25/22, at 10:33 a.m. NA-B and NA-E entered R2's room, placed lift sheet underneath R2 and transferred her from wheelchair to the bed. NA-E asked R2 if her brief was wet and R2 stated no. NA-B checked the brief and it was wet. NA-B asked R2 if they could change her brief and she stated yes. NA-B pulled R2's pants down to her knees and pulled back the brief wet with urine and tucked it between her legs. NA-B wiped from front to back with moistened wipe. R2's labia was slightly red. NA-B applied a barrier cream to the outer side of the labia with gloves on. NA-E rolled R2 onto her left side and identified a red area on R2's coccyx and verified it measured approximately 4 inches long by ½ inch wide. NA-B applied barrier cream to coccyx area and also verified there were no open areas noted. NA-B stated he had already informed the staff nurse about the red area on R2's coccyx. NA-B stated R2 liked to sit up in her wheelchair and go out and smoke. R2 was rolled onto her left side, placed a pillow underneath her back/buttocks area, covered with a blanket, and raised the head of the bed (HOB) approximately 40 degrees. NA-B and NA-E both removed their gloves, washed their hands, and exited the room. During observations on 10/25/22, R2 laid in bed from 10:33 a.m. to 3:30 p.m. identified: - at 10:45 a.m. R2 laid on back with head of bed (HOB) up to approximately 40 degrees awake.	2 920		

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2 920	Continued From page 21 -at 11:15 a.m. R2 laid on back with HOB up to approximately 40 degrees eyes are closed. -at 12:00 p.m. LPN- B entered R2's room placed a small cup of supplement in front of her on the bedside table and exited the room. R2 laid on her back with HOB up to 40 degrees awake. -at 1:10 p.m., 1:46 p.m., 2:05 p.m., and 2:44 p.m., R2 laid in bed awake on her back positioned unchanged with HOB up to 40 degrees. -at 3:30 p.m. R2 laid in bed on her back awake positioned unchanged. R2 stated she had not been changed or repositioned since before lunch. R3's quarterly MDS dated 7/20/22, identified moderately impaired cognition, diagnosis of peripheral vascular disease, and at risk for pressure ulcers. R3 required extensive assistance of one for personal hygiene, transfers, dressing, toileting use, and bed mobility, and continent of bowel and bladder. R3's care plan updated 6/28/22, listed various interventions which included assist of 1 with toileting, and transfers, monitor skin integrity daily during cares and weekly skin inspection by nurse, pressure redistribution mattress to bed and cushion to wheelchair, and monitor for skin breakdown for signs/symptoms of infection. R3's Braden scale dated 10/18/22, moderate risk for skin breakdown. R3 was incontinent of bowel and bladder, wears incontinence briefs. R3 was to be checked and changed every two hours. R3's NAR care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet. Last void 1:05 p.m. on day shift and over 7 ½ hours later 9:04 p.m. incontinent/BM.	2 920		

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2 920	Continued From page 22 -on 10/24/22, night shift care sheet. Last void 9:04 p.m. Then three hours later at 12:05 p.m., 2:07 a.m., 4:05 a.m. incontinent all three times. The 4th round no check and change was documented. -on 10/25/22, day shift care sheet. Last void at 4:05 a.m. on night shift. Three hours later at 7:05 a.m. and 9:10 a.m. dry both times. At 11:45 a.m. and 1:00 p.m. incontinent. -on 10/25/22, evening shift care sheet. Last void at 1:00 p.m. on day shift and over 8 ½ hours later at 9:47 p.m. incontinent/BM. -on 10/25/22, night shift care sheet. Last void at 9:47 p.m. then at 12:06 a.m., 2:08 a.m., and 4:30 a.m. R3 was incontinent, and 4th round no check and change was documented. -on 10/26/22, day shift care sheet. Last void at 4:30 a.m. and 5 hours later at 9:30 a.m. bed change. -on 10/26/22, evening shift care sheet. Last void at 9:30 a.m. then 5 ½ hours later at 3:00 p.m. incontinent, 5:00 p.m. incontinent, and over 4 hours later at 9:52 p.m. incontinent. -on 10/26/22, night shift care sheet. Last void at 9:52 p.m. at 12:23 a.m. R3 refused, 3 ½ hours later at 1:40 a.m. incontinent, and 4th round no check and change documented. -on 10/27/22, day shift care sheet. Last void at 1:40 a.m. and over three hours later at 4:46 a.m. incontinent. During observations/interviews on 10/25/22, from 9:15 a.m. to 1:00 p.m.: -at 9:15 a.m. R3 laid on left side with and legs hung over the side of the bed eating breakfast. -at 9:18 a.m., 9:57 a.m., 10:22 a.m., 10:30 a.m., 11:25 a.m., R3 laid in bed on her back, knees up, head of bed (HOB) up approximately 40 degrees and with lights off. -at 11:40 a.m. R3 laid in bed, knees up.	2 920		

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2 920	Continued From page 23 -at 12:15 p.m. R3 sat up in bed, leaned over and was observed picking up popcorn off the floor. NA-F entered R3's room with lunch on a tray. NA-F stated out loud "your bed is dirty, ugh"! NA-F also stated looks like we need to get in here and get you cleaned up for the day. NA-F suggested R3 eat lunch first then staff would help her after that. -at 12:37 p.m. during an interview R3 placed her call light on and stated she stayed in bed all day long and ate her meals her room. R3 also stated staff come in to change her. R3 verified it had been a while since she had been changed and needed help because she wore a brief and currently it was wet. -at 12:50p.m. NA-E entered R3's room and informed her she was going to get her cleaned up for the day. R3 requested surveyor leave room for privacy. -at 1:00 p.m. during an observation/interview NA-E opened R3's door carrying a bag of dirty linen and garbage. NA-E interviewed at that time and stated R3 used her call light "at times". NA-E also stated R3 had been incontinent of urine and an extra small bowel movement. NA-E verified R3 does not alert staff when she was wet and needed to be checked and changed every 2 hours. NA-E also verified R3's incontinent brief and lift sheet located directly underneath her was both soiled with urine/stool and had to be changed. NA-E stated it was a bit late today when R3 got cleaned up but she likes to stay in bed and that she was not sure the last time she was checked on but it would most likely be on the nurse aide care sheet that staff fill out each shift. Review of NAR care sheet (above) indicated R3 was incontinent at 11:45 a.m. and presumably changed. This documentation is inconsistent with observation and interview, given R3 had soaked	2 920		

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2 920	Continued From page 24 through both her incontinent brief and lift sheet when changed by NA-E at 12:50 p.m. R5's quarterly MDS dated 4/22/22, identified severely impaired cognition and diagnosis of dementia. R5 required extensive assistance of one for personal hygiene, dressing, bed mobility, extensive assistance of two for toileting and transfers, and supervision of cuing and encouragement with locomotion on and off the unit. R5's MDS also identified always incontinent of bladder and frequently incontinent of bowel and at risk for pressure ulcers. R5's care plan updated 6/20/22, listed various interventions which included Hoyer lift for all transfers, provide assist with bed mobility to sit up, boost up and get feet in and out of bed, turn and reposition and offload every 2 hours and as needed (PRN). Additionally, R5 required assist of 2 with toileting and transfers, extensive assist of 1 for hygiene and clothing adjustment, weekly skin audits with bath or shower, pressure redistribution mattress to bed and wheelchair, and assist with movement in bed. R5's NAR care sheets provided the following information regarding transfers, bed mobility, repositioning, toileting, and eating: -on 10/24/22, evening shift care sheet last void at 11:50 a.m. over 7 hours at 7:45 p.m. incontinent, and 9:16 p.m. incontinent. -on 10/24/22, night shift care sheet last void at 9:16 p.m., 12:23 a.m. incontinent, 2:23 a.m. incontinent, 4:20 a.m. incontinent, and 4th round no check and change was documented. -on 10/25/22, day shift care sheet last void at 4:20 a.m., over 2 1/2 hours at 7:15 a.m. incontinent, 3rd round no check and change was documented, and over 6 1/2 hours at 2:00 p.m.	2 920		

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2 920	Continued From page 25 incontinent. -on 10/25/22, evening shift care sheet last void at 2:00 p.m. over 4 ½ hours at 6:58 p.m. incontinent, and 9:12 p.m. incontinent. -on 10/25/22, night shift care sheet last void at 9:12 p.m., over 3 hours at 12:23 a.m. incontinent, 4:30 a.m. incontinent, and 4th round no check and change was documented. -on 10/26/22, day shift care sheet last void at 4:30 a.m. 6:00 a.m. 11:05 a.m. incontinent, and 12:50 p.m. incontinent. -on 10/26/22, evening shift care sheet last void at 12:50 p.m., over 6 hours at 7:10 p.m. incontinent, and 9:45 p.m. incontinent. -on 10/26/22, night shift care sheet last void at 9:45 p.m., over 2 hours at 12:07 a.m. incontinent, 2:10 a.m. incontinent, 4:20 a.m. incontinent. During observations on 10/25/22, from 9:36 a.m. of R5 identified: -at 9:36 a.m. R5 sat in wheelchair in dining room next the window with her cloth protector still on from breakfast. -at 10:48 a.m. R5 sat in dining room still had clothing protector on from breakfast. R5 faced the window pulled, and folded panel curtain of windows. -at 11:30 a.m. R5 is sat in dining room same position, location, and still had clothing protector on. -at 12:16 p.m. R5 ate lunch with assistance in dining room used same clothing protector from breakfast, no observation of R5 leaving dining area for check and change before lunch. -at 12:46 p.m. R5 still sitting in dining room appeared to be done eating and still drinking. -at 2:00 p.m. NA-B entered the dining room and asked R5 if she was ready to use the bathroom. NA-B pushed R5 in wheelchair out of dining room, down the hallway, and into the	2 920		

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2 920	Continued From page 26 bath/toileting room. NA-B used the ceiling lift to transfer R5 from wheelchair to toilet. R5 was incontinent of urine and stool and incontinence product was observed to be saturated. While observing NA-B stated staff are assigned to a hallway and they work as a team to make sure all the residents are getting their check and changes completed. NA-B also stated staff use a nursing assistant record (NAR) sheet they sign off what has been completed. NA-B verified R5 sometimes used a call light but when she sat in the dining room would most likely would not have told a staff if she needed the bathroom. NA-B stated any of the staff that worked in this hallway would have been responsible to check and change R5 but would have to look at the NAR sheet to see who checked on her last and what time. Review of R5's NAR care sheet indicated she did not receive a check and change for 6 ½ hours before getting changed at 2 p.m. on 10/25/22. During an interview on 10/26/22, at 10:31 a.m. NA-G stated there was a big issue with some staff not completing check and changes correctly. NA-G indicated some residents did not receive adequate check and changes and sat in their urine and feces longer than appropriate. NA-G also stated this had been reported before and it was investigated but no real improvement was made. During an interview on 10/26/22, at 11:35 a.m. director of nursing (DON) stated if a resident was independent staff would be expected to have checked on them and identify what they did for them on the NAR care sheet. DON also stated if a resident required assistance to remain continent and/or repositioning that should be	2 920		

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2 920	Continued From page 27 identified on the NAR sheet with repo, and I/C (Incontinent/Continent). During an interview on 10/26/22, at 3:50 p.m. RN-A staff are expected to document the residents needs such as when they were last toileted or checked and changed on the NAR care sheets. RN-A indicated she expected the floor nurse to check the NAR sheets at the end of the shift to identify if the toileting is being completed. RN-A stated staff are expected to use the same codes to document on the NAR care sheets such as D for dry and I for incontinent. RN-A verified there had been many times staff had complained the documentation was not being done. During an interview on 10/27/22, at 11:08 a.m. NA-C stated R2 required total assistance of two for incontinence cares and repositioning. NA-C staff are expected to check and change and reposition R2 every two hours. NA-C stated R3 required total assistance with cares with two staff. NA-C indicated staff are to document toileting and check and changes on the NAR care sheets and currently the repositioning should be documented on there also. NA-C verified R5 was total assistance at all times of two staff and staff were expected to toilet her at least every two hours or less. Toileting and incontinence care policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review ADL policies for providing assistance with toileting with direct care staff members and provide education as needed. The DON or designee could then develop and implement an	2 920		

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2 920	Continued From page 28 auditing system as part of their quality assurance to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to offer sufficient fluid intake to maintain proper hydration and health for 3 of 4 (R2, R3, R5) reviewed for hydration. This had the potential to affect all 59 residents residing in the facility. Findings include: R2's quarterly minimum data set (MDS) dated 9/19/22, identified moderately impaired cognition. R2 required extensive assistance of one for personal hygiene, bed mobility, dressing, toilet use, independent with eating set up only, and total dependence with transfers. R2 also received a diuretic (water pill) daily. During an observation/interview on 10/25/22, at 10:45 a.m. R2 laid in bed and on bedside table was an empty sippy cup and mug with a cover on it. F2 stated the water that had been in her mug was from last night and she had not been drinking it. R2 also stated she wanted fresh water and	2 940	Corrected	12/2/22

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2 940	Continued From page 29 staff had not offered her any when in the room. During an observation on 10/25/22, at 12:00 p.m. LPN-B entered R2's room with a small cup of supplement, placed it in front of R2 and next to her empty container of water. LPN-B did not offered water or fill the water container. During an observation/interview on 10/25/22, at 1:46 p.m. R2 laid awake on her back with head of bed up 45 degrees. R2's mug at bedside had a cover on it with approximately 100 ml of clear liquid in it and an empty sippy cup. R2 stated they still have not brought me fresh water and would really like some while she pointed at the empty cup with her right hand. R2 also stated she would like something more to drink and not sure why they are not able to bring fresh water. R2 indicated she had asked staff for fresh water this morning but had not received it. During an observation on 10/25/22, at 2:44 p.m. and 3:30 p.m. R2 laid in bed and did not have fresh water/liquids available to her and nothing reachable. During an interview/observation on 10/26/22, at 9:04 a.m. R2 sat in her wheelchair in her room. Located next to R2 on bedside table was a sippy cup with a cover and straw in it and approximately 2 ounces of brown liquid noted in it and a mug with a cover and straw in it with a small amount of water in the bottom of it. R2 stated my friend came by and brought me some root beer pop, placed it in that cup for me, and drank most of it maybe 6 ounces or so. R2 verified the water mug was the same as yesterday with only a small amount of water in it and had not been filled with fresh water for a couple of days by her friend. R2 stated I thought about asking about it when they	2 940		

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2 940	Continued From page 30 brought fresh water in for my roommate yesterday, but they were cleaning me up. R2 also stated I wanted to say to them "what about me I would like some cold water too". R2 indicated when she asked for fresh water, they eventually bring it but keep forgetting. During observation on 10/26/22 at 10:41 a.m. the dietary staff was bringing water to resident on the unit. R2 was in her room and water was observed to be brought in for her roommate. No water was observed to be offered to R2. During observation and interview on 10/26/22 at 12:23 p.m. R2 was lying in bed, surveyor had asked if she would be having lunch and she said no, that she was not hungry. When asked if she had received any water yet, R2 stated she had not and she did not know why adding, the staff were in here and that her roommate got fresh water so she did not understand why she could not get some, but she would like some. During observation and interview on 10/26/22 at 3:01 p.m. R2 was still lying in bed and confirmed she did not have fresh water yet, mug and glass on bedside table still appeared to be untouched. Surveyor requested water from staff. During an observation on 10/27/22 at 11:28 a.m. located on R2's bedside table was a small amount of clear liquid approximately 100 millimeter (ml) in a covered mug, an empty sippy cup with a straw in it, and small glass half full thicken apple juice. No fresh water noted in R2's room. During an interview on 10/27/22, at 11:08 a.m. NA-C stated R2 does not care for honey thick liquids or thickened water, and maybe drinks 240	2 940		

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2 940	Continued From page 31 ml a shift with meals. NA-C also stated staff are expected to offer fluids to each resident when in their room to help prevent dehydration. NA-C stated R2 refused honey thickened liquids frequently however staff were expected to offer R2 thicken liquids throughout the day. R3's quarterly MDS dated 7/20/22, identified moderately impaired cognition. R3 required extensive assistance of one for personal hygiene, transfers, dressing, toileting use, bed mobility, and independent with eating set up only. R3's physician orders dated 8/9/22, identified push fluids and monitor every shift During an observation on 10/25/22, at 9:18 a.m., 9:57 a.m., 10:30 a.m., 10:50 a.m., and 11:00 a.m. R3 laid on her back in bed, knees bent with head of bed up to 40 degrees. R3 had a full glass of thickened apple juice on her bedside table. No water available or observed in room. During an observation on 10/25/22, at 11:25 a.m. resident laid in bed on her back with knees bent. Only one-fourth of the thickened apple juice remained in the glass. No water available within reach. During an observation on 10/25/23, at 12:15 p.m. NA-F entered R3's room and placed her dinner tray on her bedside table. R3 had two glasses of thickened apple juice and no water. During an observation on 10/25/22, at 12:45 p.m. NA-E entered R3's room, asked her if she was still working on your lunch and R3 stated hardly. Two small glasses of thicken liquid were noted on the bedside table. One glass was three fourths full and the other one completely full. NA-E	2 940		

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2 940	Continued From page 32 offered to leave the two small glasses of honey thick liquid apple juice but R3 refused and stated she had enough of that kind of stuff and was getting tired of drinking it. No water was provided or offered at that time. During an interview/observation on 10/25/22, at 1:00 p.m. NA-E entered R3's room and she requested surveyor leave the room while NA-E completed a check and change. At 1:10 p.m. NA-E opened R3's room door. NA-E stated R2 was currently on a pureed and honey thick liquid diet and does not like thicken liquids. NA-E also stated R2 drank water every day and an assigned staff NA-D offered it daily to her and everyone in the facility but not sure why R2 did not have water in her room to drink today. NA-E completed the interview and did not provide or offer R3 water. During a telephone interview on 10/26/22, at 11:36 a.m. a family member (FM)-A stated [R3] loved to drink boost and does not get them anymore. FM-A indicated [R3] was not receiving enough fluids, loves water but does not like the thickening. FM-A also stated staff quit giving [R3] water since she had swallowing problems and aspirated in the hospital. FM-A verified it had been two months since she had seen water in her room and other than that pop was all she had been drinking. FM-A stated she had asked [R3] about receiving water and she indicted she been receiving water. R5's quarterly MDS dated 4/22/22, identified severely impaired cognition. R5 required extensive assistance of one for personal hygiene, dressing, bed mobility, extensive assistance of two for toileting and transfers, and supervision of cuing and encouragement with locomotion on and off the unit and eating.	2 940		

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2 940	Continued From page 33 During an observation on 10/25/22, at 9:26 a.m. R5 sat in wheelchair by window and still had clothing protector on from breakfast. During an observation on 10/25/22, at 10:48 a.m. R5 sat in wheelchair in dining room still had clothing protector on with milk and juice on table. R5 faced the window and pulled on the folding panel curtain blind. During an observation on 10/25/22, at 11:30 a.m. R5 sat in wheelchair in dining room in same position and location, still had clothing protector on and drinks on table had been removed. During and observation on 10/25/22, at 12:16 p.m. R5 ate lunch with assistance in dining room and had same clothing protector on as for breakfast. During a continuous observation on 10/25/22, from 1:30 p.m. to 2:00 p.m. R5 sat in wheelchair awake by the window in the dining room: -at 1:41 p.m. nurse assistant (NA)-A entered the dining room, approached an unidentified resident, asked if interested in attending activities, then pushed resident in wheelchair out of the dining room and down the hallway. No fluids offered to R5 during this observation. -at 1:48 pm NA-B entered the dining room said hello to R5, exited the room, walked down the hallway, and entered another resident's room. No fluids offered to R5 during this observation. -a 1:52 p.m. licensed practical nurse (LPN)-B entered the dining room, grabbed juice out of the refrigerator, glanced over at R5, walked out of the room while she held the containers and stated, "I need to get stocked for the evening shift". No	2 940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00583	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/27/2022
NAME OF PROVIDER OR SUPPLIER THE WATERVIEW WOODS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 601 GRANT AVENUE EVELETH, MN 55734		
(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
2 940	Continued From page 34 fluids offered to R5 during this observation. Observation 10/26/22 at 2:00 p.m. R2 was taken to bathroom for check and change. She was lifted back into her wheelchair and pushed back into the dining room. No fresh water was offered. During an interview on 10/26/22, at 3:50 p.m. RN-A stated NA-D was expected to pass fresh water to the residents during the day shift. RN-A indicated all residents should receive water unless they are on a special diet then they would have received thicken water, and maybe a smaller portion. RN-A stated it would be important to provide fresh water to all residents to help prevent dehydration. During an interview on 10/27/22, at 8:31 a.m. dietary manager (DM) stated nursing staff are expected to pass fresh water at least twice a day usually between breakfast and lunch and also between lunch and supper. DM also stated fresh water was expected to be given to all residents cleared to drink regular liquids. DM indicated residents on special diets are usually ones that do not have the initiative to drink on their own and therefore staff are expected to offer water during medication past time, during cares, and whenever in the resident's room to keep their fluids up and hydrated. During an interview on 10/27/22, at 10:30 am RN-C stated NA-D was assigned to pass fresh water to all residents but not sure how often. RN-C also stated those residents on a special diet such as nectar thicken liquid should have received thicken water. RN-C indicated residents become dehydrated, which can be very serious, and end up in the hospital very quickly.	2 940		

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2 940	Continued From page 35 During an interview on 10/27/22, at 11:50 a.m. the director of nursing (DON) stated the nursing assistants and the direct care staff are expected to provide fresh water once a day every day and offer water to each resident during completion of cares, assisting residents, and during rounds. DON verified staff are also expected to offer thicken fresh water to the residents on special diets. DON stated residents are at risk for hydration problems and fresh water helped prevent dehydration. Review of facility policy titled Hydration revised 9/2012, identified the facility will provide adequate hydration to each resident to achieve and maintain overall health status by taking into consideration each resident's underlying disease state, mental and physical limitations; unless the resident's clinical condition indicates that a decline is unavoidable. Dehydration in the elderly has long been considered a significant health problem which can lead to increased morbidity and mortality, and costly medical care. The following are risk factors for dehydration: inability to obtain water freely, due to any number of conditions such as stroke, impaired movement, impaired cognition, and impaired communication. SUGGESTED METHOD OF CORRECTION: The dietary director could review the dietary assessments to identify residents at risk for dehydration. For any residents identified as at risk for dehydration the dietary director or designee could review the care plan to ensure the resident's hydration needs were being addressed and monitored. Nursing staff could then be educated on those residents at risk for dehydration and how to monitor the resident is receiving enough fluids to maintain adequate hydration.	2 940		

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2 940	Continued From page 36	2 940		
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper sanitization of shared glucose meter (device to test blood sugar levels) for 1 of 1 resident (R7) when observed use for shared medical equipment. Findings include: R7's quarterly minimum data set (MDS) dated 9/29/22, identified R7 intact cognition, extensive assistant with all activities of daily living, transfers, and medical diagnoses of diabetes mellitus (DM). R7's electronic medication administration record (EMAR), 10/26/22, at 11:01 a.m. identified a blood glucose level of 148 milligrams/deciliter (mg/dl) had been completed by licensed practical nurse (LPN)-A. During an observation on 10/26/22, at 11:00 a.m. LPN-A exited R7's room, held a square plastic	21385	Corrected	12/2/22

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21385	Continued From page 37 container in her right hand containing a glucose meter positioned on top of alcohol swabs, gaze pads, lancets, and a container of glucose test strips. LPN-A placed the container on top of the medication cart, sanitized her hands, logged onto computer, and documented R7's blood glucose level. At 11:10 a.m. LPN-A locked medication cart and computer screen and walked down the hallway. During an interview on 10/26/22, at 11:10 a.m. LPN-A verified she had used the glucose meter taken from on top of the medication cart and checked R7's glucose level. LPN-A stated she had not disinfected/cleansed the glucose meter, was here all day working, and no one else will use it. LPN-A identified the dirty glucose meter laid on top of the supplies located in the square plastic container. LPN-A stated R7 had her own glucose meter in her room and grabbed the one on top of the medication cart instead, brought it into her room, and checked a blood glucose level. LPN-A identified nursing staff are expected to disinfect the glucose meter prior to placing back into the container with the supplies to help prevent spread of germs. LPN-A stated the glucose meter was an extra one and would mostly likely not be used on other residents but possibly could be used on a resident that was crashing or a newly admitted diabetic. During an interview on 10/26/22, at 3:50 p.m. registered nurse (RN)-A stated nursing staff are expected to use the glucose meter provided for each diabetic resident located in their room. RN-A indicted the glucose meter located on the medication cart should not be used on any residents. RN-A verified community blood sugar monitoring should not be going around and completed with the same glucose meter. RN-A	21385		

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21385	Continued From page 38 also stated the glucose meter should be cleaned off with sanitizing wipes before and after use and should not be placed on top of supplies until cleansed. During an interview on 10/27/22, at 10:49 a.m. RN-B stated all diabetic residents should have their own glucose meter in their room. RN-B also stated she was not sure why two extra glucose meters were kept on the medication carts but maybe would be used after a fall and a glucose level needed to be checked. RN-B stated the glucose meter could be used on multiple residents only if it had been cleaned and disinfected properly. RN-B also stated we want to avoid transmission of germs from hands, from one resident to another, and for infection control. During an interview on 10/27/22, at 11:50 p.m. with director of nursing (DON) stated each diabetic resident has their own glucose meter and should not be used on multiple residents due to risk of infection. DON also stated the extra glucose meter on the medication cart was used in case another one quite working. DON indicated staff would be expected to sanitize the glucose meter before and after use and prior to placing it back into the medication cart to help prevent infection. Review of facility policy titled Obtaining a Finger Stick Glucose Level dated 2001, identified always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. Review of the manufacturer's instructions titled	21385		

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21385	Continued From page 39 Assure Prism Multi blood glucose monitoring system dated 2020, identified to minimize the risk of transmitting blood borne pathogens, the cleaning and disinfection procedure should be performed after use on each patient. The Assure Prism Multi-Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure with the first wipe and disinfecting procedure is needed to prevent the transmission of blood borne pathogens with a second wipe. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood-borne pathogens. SUGGESTED METHOD OF CORRECTION: Staff could be re-educated on infection control practices during glucometer cleaning. The director of nursing or designee could perform random audits to ensure staff are following infection control practices when cleaning a glucometer. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21385			