Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
April 29, 2025

Administrator
Olivia Restorative Care Center
1003 West Maple Avenue
Olivia, MN 56277

RE: CCN: 245290
Cycle Start Date: April 9, 2025

Dear Administrator:

On April 9, 2025, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be **widespread deficiencies that constituted immediate jeopardy (Level L)** whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On April 8, 2025, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

In addition, on April 9, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 location for imposition. The CMS location 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 May 14, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 14, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 14, 2025, (42 CFR 488.417 (b)).

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.

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 $13,343; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 9, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

If you have not achieved substantial compliance by May 14, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Olivia Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 14, 2025. 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80

Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Olivia Restorative Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 9, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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 "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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, Licensing and Certification Program 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 October 9, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services

determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 29, 2025

Administrator
Olivia Restorative Care Center
1003 West Maple Avenue
Olivia, MN 56277

Re: State Nursing Home Licensing Orders
Event ID: 93MR11

Dear Administrator:

The above facility was surveyed on April 1, 2025 through April 9, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING _____ B. WING _____	C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE AVENUE OLIVIA, MN 56277

(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 4/1/25 thru 4/4/25 and 4/8/25 and 4/9/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in immediate jeopardy (IJ) to resident health and safety at F880 and F689. 1) An IJ F880 began on 3/16/25, when the facility failed to implement infection control strategies for respiratory protection to mitigate the risk and spread of Respiratory Syncytial Virus (RSV- an infection of the respiratory tract). Furthermore, the facility failed to initiate enhanced barrier precautions for residents with wounds requiring dressing changes, indwelling medical devices (i.e., catheter, g-tube; R1, R4 and R5). The administrator, and director of nursing (DON) were notified of the IJ on 4/4/25 at 3:30 p.m. The IJ was removed on 4/8/25 at 6:32 p.m.. 2) An IJ F689 The IJ began on 3/28/25 after R20 had a fall, the facility failed assess and implment appropriate interventions to prevent/mitigate risk for falls which resulted in R20's fall on 4/4/25 in which R20 suffered an intercranial brain injury and hospitalization. The Administrator, director of nursing (DON) were notified of the IJ on 4/8/25 at 6:32p.m. The immediate jeopardy was removed on 4/9/25 at 4:40 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 4/9/25.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/08/2025

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 000	Continued From page 1 The following complaints were reviewed: H52902685C (MN00112052) with deficiencies cited at F689 and F880. In compliance: H52901666C (MN00111541), H52909781C (MN00111297), H52902130C (MN00111710 and MN000111797), H52902350C (MN00111846), 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 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess falls for root cause, revise the care plan and implement appropriate interventions to	F 689	F689: 1. Corrective Action will be accomplished for the residents as followed: 39 residents will be comprehensively reviewed through	5/13/25

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F 689	Continued From page 2 prevent and/or reduce the risk of falls with major injury for 2 of 3 residents (R20, R22) who had falls. This resulted in an immediate jeopardy for R20 who had a history of traumatic brain injuries and sustained a fall that resulted in a subdural hematoma and was hospitalized. The IJ began on 3/28/25 after R20 had a fall, the facility failed to assess and implement appropriate interventions to prevent/mitigate risk for falls which resulted in R20's fall on 4/4/25 in which R20 suffered an intercranial brain injury and hospitalization. The Administrator, director of nursing (DON) were notified of the IJ on 4/8/25 at 6:32p.m. The immediate jeopardy was removed on 4/9/25 at 4:40 p.m., but non-compliance remained at the lower scope and severity level D, which indicated no actual harm with the potential for more that minimal harm that is not immediate jeopardy. Findings include: R20's face sheet dated 4/9/25, identified R20 was admitted on 3/26/25 with diagnoses including subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), fracture of skull, and intracranial injury. R20's Brief Interview for Mental Status (BIMS) dated 3/27/25 identified R20 had severe cognitive impairment. R20's fall risk assessment dated 3/26/25, identified R20 was high risk which identified risk factors of disorientation at all times; three or more falls in the past three months; poor vision; balance problem while walking; requires assistive device; and required 1-2 medications that could	F 689	the use of the PCC Fall Risk Assessment. 7 residents who had falls in the last 30 days will have a PCC Fall Risk Assessment and a comprehensive review of their falls through information documented in a progress note titled, "Post-Fall Assessment" Education includes fall program processes, notifications of important people. Knowledge test is attached to the fall education. Nurses will be educated on documentation related to interventions effectiveness in progress notes and other appropriate documentation through revised checklist including updating the care plans and completing progress notes in a timely manner. Information in the progress notes will be reviewed at IDT to assist with Post Fall Assessment. Education to be completed by 4/11/2025 for All staff prior to the start of their next shift. 2. The facility will identify other residents who have the potential to be affected for high fall risk status. 7 residents were identified as moderate fall risk; 39 residents identified as high fall risks. 3. Facility reviewed fall program and policies. Fall documentation has been altered to include an "initial fall note," PCC order to prompt chart charting for fall and vitals X3 days, and "Fall-Post Fall" template to coplete x3 days for documentation of effectiveness of intervention. Initial Fall Note reviews the causality of the residents fall to identify an appropriate intervention. "Post-Fall	

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F 689	Continued From page 3 cause lethargy or confusion. The report also identifed R20 had 1-2 predisposing diseases that increased R20's risk for falls but did not specify which pertained; the listing of risk diagnoses included circulatory, neuromuscular/functional, orthopedic, perceptual, psychiatric/cognitive, infection, pain/headache, fatigue/weakness, weight loss, vitamin D deficiency and history of falls. R20's progress note dated 3/26/25, director of nursing (DON) identified R20 was admitted with multiple facial fractures and a traumatic brain injury. Report from the hospital said his blood pressure runs low most of the time, does not remember this and gets up alone, wanders outside of his room, and goes to the bathroom alone. R20's progress note dated 3/27/25 at 11:07 a.m., identified R20 can use the bathroom independently. R20's progress note dated 3/28/25 at 12:57 a.m., identified R20 was independent with toileting, transfers, and ambulating. R20's record between 3/26/25 through 4/3/25 did not include a care plan for falls despite R20's high risk for falls identified on the fall risk assessment completed on 3/26/25. R20's unwitnessed fall incident report dated 3/28/25 at 6:00 a.m., identified R20 was found sitting on the floor by his bathroom. Intact range of motion. Denied pain and alert and oriented x 1 with some confusion. Unable to use the call light. R20 was given gripper socks which he had taken off. Staff to check often (frequency not specified).	F 689	Assessment" note template to be completed with IDT on next business day excluding weekends to determine effectiveness of interventions and other potential risk factors. 4. Audits will be completed for all residents to have a falls care plan focus, timely intervention, implementation after a fall, comprehensive reviews of falls and care plans being updated will be completed weekly X3, monthly X3 to assure continued compliance and reviewed at QAPI with the involvement of the facility Medical Director. 5. Correction Date: May 13, 2025	

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F 689	Continued From page 4 The report did not identify if R20 was incontinent and/or he was attempting to use the toilet. Although the report identified potential causal/risk factors of confusion, unable to use the call the call light, and had taken off gripper socks, the report did not include a comprehensive fall analysis. The report indicated on 3/31/25 the facility developed a fall intervention to add a soft touch call light and gripper socks. However, R20's care plan did not identify R20's high risk for falls or include the interventions of soft touch call light, gripper socks, and staff to check often. Further, R20's record did not include a comprehensive assessment that identified the level or frequency of supervision that corresponded with the intervention of "staff to check often". R20's progress note dated 3/29/25 at 11:52 a.m., included R20 had wandered into hallway three times and needed to be redirected back to room. R20's physical therapy noted dated 3/31/25, included R20 was a fall risk and ambulates to the bathroom without asking for assistance. R20 was educated on the call light and coordination with nursing. The note did not identify what was coordinated with nursing. R20's unwitnessed fall incident report dated 4/1/25 at 10:00 p.m., identified nursing assistant went to check on resident per nurse request and R20 was found on floor by television. R20 "was towards the door" and head by the bedside table with head of bed elevated. R20 stated he missed his bed walking backwards. No other information was included. R20's record did not include a comprehensive fall assessment/analysis that identified probable causal factors/root cause with	F 689		

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F 689	Continued From page 5 corresponding individualized interventions to prevent and/or mitigate the risk of falls. Interventions that were identified included room was re-arranged and bed moved against the wall and frequent (was not specified) checks at night initiated. However, R20's care plan for falls was not developed (there was no care plan) and the record did not include a comprehensive assessment that identified the level or frequency of supervision that corresponded with the intervention "frequent checks" at night. R20's progress note dated 4/4/25 at 4:25 a.m. indicated R20 had an unwitnessed fall in his room. Staff heard a loud noise and found R20 leaning on the wall by the television. R20 reported he hit his head and was complaining of pain in both lower and upper extremities, R20 was given Tylenol, vital signs were taken. and he was sent to the emergency room (ER) R20's hospital imagining report dated 4/4/25, identifed a head computed tomography (CT) was performed following a fall with head injury with a critical result of a new intercranial hemorrhage or herniation. R20's hospital emergency department to hospital discharge summary dated 4/5/25, identified R20 admitted to hospital on 4/4/25 to 4/5/25, following a fall and was noted to have a subdural hematoma on computed tomography (CT) scan. R20 was discharged back to facility on 4/5/25. R20's unwitnessed fall incident report dated 4/4/25 at 4:20 a.m., identified a loud noise heard from room and R20 found leaning on the wall by the television. R20 stated he hit his head and complaining of pain in ribs and left arm. R20 sent	F 689		

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F 689	Continued From page 6 to emergency room for evaluation. R20's record did not include a comprehensive fall assessment/analysis that included potential causal factors/root cause for the development of individualized interventions to prevent or mitigate the risk of falls and/or falls with major injury. Additionally, no additional fall interventions were documented in the fall report. R20's progress note dated 4/5/25, identified R20 returned to facility after being sent to the hospital following a fall and sustaining a subdural hematoma and report from the hospital there will be no changes. Review of R20's record did not identify the care plan was revised/updated upon or after R20's return from the hospital. R20's progress note dated 4/7/25 at 9:09 a.m., identified R20 was walking to the bathroom and staff witnessed R20 falling by his closet door, and he was then assisted to ground. R20 had been seen less than 15 minutes before the fall. R20 reported he became dizzy while self-transferring. R20 was wearing gripper socks. Immediate intervention was orthostatic blood pressures and prompted to use the toilet. Pharmacy was notified for medication review. Review of R20's physician orders/treatments identified the directive to obtain orthostatic blood pressure was not transcribed until 4/8/2025. Additionally, review of R20's record did not identify a comprehensive analysis for causal factors/root cause. Further, R20's record identified although the care plan had been revised on 4/8/25 to include every 1-2 hours prompting for toilet use, the record did not include a corresponding comprehensive bowel/bladder assessment that would identify the appropriateness of the intervention to meet R20's individualized toileting needs.	F 689		

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F 689	Continued From page 7 Although the facility developed and implemented R20's fall care plan on 4/4/25, the care plan did not include the interventions of 'soft touch call light', and 'staff to check often' that were identified on 3/28/25 fall report and did not include 'frequent checks at night' and bed up against the wall that was identified on the 4/1/25 fall report. R20's fall focus care plan initiated on 4/4/25, identified R20 was high risk for falls related to unspecified intracranial injury, anxiety disorder, traumatic subarachnoid hemorrhage, atrial fibrillation and incontinence. R20 will often get up on his own, not use the call light to alert staff even with numerous staff reminders and encouragement. Interventions included: anticipate resident's needs, be sure call light is within reach and encourage to use it for assistance, prompt responses for all requests for assistance, and ensure wearing appropriate non-slip/non-skid footwear when ambulating or mobilizing in wheelchair. During an interview on 4/8/25 at 10:15 a.m., nursing assistant (NA)-K stated R20 did not use his call light and has attempted to self-transfer many times since admission due to being confused at times. Staff have been doing frequent checks, however at times when NA-K was busy assisting other residents he could not check on R20 as frequently as he should. NA-K also stated R20's care plan did not identify a timeframe of how often the frequent checks should be done. NA-K explained frequent checks means for staff to "just look in [R20's] room" to see what he was doing, NA-K was unable to define the time frame of "frequent checks" as the care plan was not specific. NA-K indicated he thought there was a form for R20's "checks" staff	F 689		

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F 689	Continued From page 8 were supposed to complete, however, was not aware of the location of where it was kept so had not completed the form. During an interview on 4/8/25 at 10:50 a.m., trained medication aide (TMA)-D stated since admission R20 will self-transfer and had been found wandering in the hallway; staff would then assist him back to his room. Staff check on R20 often to ensure he was not self-transferring. TMA-D further explained to her "check often" meant look in R20's room every time she would passed by. TMA-D could not define a specific timeframe of how often checks were supposed to be completed and was not aware how often staff pass by R20's room. TMA-D was unaware of any other fall interventions in place for R20. During an interview on 4/8/25 at 11:12 a.m., licensed practical nurse (LPN)-C stated R20 would self-transfer to the bathroom on his own without asking for help. LPN-C stated a visual every 15-minute paper checklist was implemented for R20 on 4/8/25, it was kept in a binder at the nurse's station. LPN-C reviewed the checklist for 4/8/25 and noted the checks were not consistently completed so far today (4/8/25). LPN-C then reviewed the care plan and noted the intervention for every 15-minute checks was not identified on R20's care plan. During an interview on 4/9/25 at 12:57 p.m., registered nurse (RN)-C stated she completed the care plans for all of the residents in the facility upon admission. RN-C verified R20's admission fall risk assessment identified him as a high fall risk and that R20's fall risk care plan had not been initiated until ten days after admission. RN-C indicated fall causal analysis was	F 689		

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F 689	Continued From page 9 completed by the interdisciplinary team (IDT). RN-C used to be a part of that team but no longer was. When she was part of the team she would assist in determining the appropriate interventions and then would add them to the care plan. During a phone interview on 4/4/25 at 12:38 p.m., emergency room medical doctor (MD)-H reported concerns pertaining to falls. R20 had been seen in the emergency department (ED) due to a fall in the facility and sustained a subdural hematoma and needed to be transferred to another hospital for further evaluation. During an interview on 4/9/25 at 4:23 p.m., certified nurse practitioner (CNP) stated R20 was "extremely elevated risk for falls" due to confusion and ability to transfer independently. CNP's expectation would have been for the facility to put fall prevention interventions in place on admission to the facility. CNP also stated due to R20's history of previous brain injuries prior to admission with any future falls with head injury could have the likelihood of serious injury, harm, impairment or even death. During an interview on 4/8/25 at 12:40 p.m., director of nursing (DON) identified R20 did not have a fall prevention care plan until after his fall on 4/4/25. DON stated R20 should have had a baseline care plan completed during the first forty-eight hours to identify his fall risk and had interventions in place at admission. DON also stated a comprehensive assessment of his falls, causal analysis, or root case of the falls to add appropriate interventions to prevent further falls had not been completed for any of R20's falls and should have been done.	F 689		

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F 689	Continued From page 10 The IJ began on 3/28/25. was removed on 4/9/25 at 4:40 p.m., when it was verified, the facility implemented the following: 1. Facility reviewed and revised fall program and policies to define protocols for documentation with new templates developed and implemented. The revisions included role/responsibilities for the IDT. 2. Facility provided education with knowledge check to nurses on the fall program process, completing the falls checklist, completing the implemented documentation, implantation of interventions, reviewing the effectiveness of the intervention, and updating the care plan. A knowledge test was attached to the fall education. 3. Facility provided education NAs on care plan and roles in the facility's fall program. 4. Facility provided education to IDT on roles and responsibilities pertaining to the fall program. 5. Facility reviewed R20's chart for fall incidences and fall analyzes. Care plan were reviewed and updated with fall interventions. Interdisciplinary team reviewed R20 to see if other modifiable risk factors can be implemented for resident. 6. Like residents were identified, facility completed comprehensive analysis, reviewed and revised care plans as appropriate. R22 R22's face sheet dated 4/10/25, identified R22 was admitted on 3/20/25 with diagnoses of fracture of right fibula, fracture of right rib, degeneration of nervous system, and schizoaffective disorder. R22's fall risk assessment dated 3/20/25, identified R22 was high risk for falls with 1-2 fall in past 3 months, chair bound, with predisposing	F 689		

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F 689	Continued From page 11 disease or circulatory/heart, neuromuscular/functional, orthopedic, psychiatric/cognitive, infection, pain, weakness, and history of falls. R22's fall incident report dated 3/23/25 at 4:10 p.m., identified R22 was found on the floor next to his bed. R22 stated he was attempting to reach his remote to the television and slid from the bed. Incident report was not completed to include mental status, predisposing physiological/environmental factors/situation factors. On 3/31/25 incident report identified new intervention of reached out to pharmacist of new recommendations. R22's care plan did not identify a fall focus care plan had been initiated, or any fall prevention interventions added. A post-fall root cause analysis worksheet was provided for R22's fall on 3/23/25, identified R22 was found on floor next to his bed, R22 was laying in bed watching television and dropped the remote and wanted to get it from the floor, call light was in reach, last toileted at 3:50 p.m., was not incontinent at time of fall, and had gripper socks on. Interventions put in place of frequent call light checks and request nursing assistants to check on resident often. Although the worksheet identified possible causal factors of the fall, no conclusion of the data was identified in the medical record to determine the root cause of the fall. R22's fall incident report dated 3/24/25 at 9:30 p.m., identified R22 was being assisted with transfer from bed to wheelchair and resident became weak and was lowered to the ground. Incident report was not completed to include mental status, predisposing physiological/environmental factors/situation	F 689		

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F 689	Continued From page 12 factors. R22's care plan did not identify a fall care plan focus medical record did not identify comprehensive assessment, causal analysis, or root cause of the fall. R22's fall care plan focus dated 3/25/25, identified R22 was high risk for falls related to non-weight bearing of right foot, repeated falls, schizoaffective disorder bipolar type, spondylosis, inability to follow directions and impulsivity. Interventions included: anticipate and meet the resident's needs, be sure call light is within reach and encourage and remind the resident to use it for assistance as needed. R22's activities of daily living (ADL) focus care plan dated 3/25/25, identified R22 required assist of two for all transfers and not able to follow directions for non-weight bearing of right foot. R22's consultant pharmacist review on 3/29/25, a medication review done due to frequent falls and recommended adjustments to fall risk medications. Review of R22's progress notes from 3/29/25 to 4/7/25 did not identify physician notification of consulting pharmacist recommendations until 4/8/25. R22's fall incident report dated 3/26/25 at 5:30 p.m., identified R22 was on floor sliding to the bathroom attempting to toilet himself. R22 was in bed prior to the fall and call light was on the bed. R22 was last toileted at 2:30 p.m., repositions self and had a large loose bowel movement. Fall mat was place on the floor and frequent checks to assure needs are met, and soft touch call light. R22's post-fall causal analysis worksheet dated 3/26/25, identified the aforementioned fall description and identified R22 was incontinent at time of fall. Although the worksheet identified	F 689		

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F 689	Continued From page 13 possible causal factors of the fall including R22 was incontinent, no conclusion of the nor evident comprehensive assessment completed that addressed R22's toileting needs. Further R22's care plan did not identify the new interventions of fall mat, frequent checks, nor soft touch call light that were identified on fall report. Furthermore, R22's record identified although the care plan had been revised on 4/8/25 to include frequent checks-15 min checks. R22's record did not include a comprehensive assessment that identified the level or frequency of supervision that corresponded with the intervention "frequent checks". R22's progress note dated 4/7/25, identified R22 was found sitting on the fall mat because he slipped due to slippery floor. R22 was coming back from bathroom. Immediate intervention to offer toileting every hour. R22's care plan was not revised on 4/7/25 to include offer toilet every hour. R22's record identified although the care plan had been revised on 4/9/25 to include every 2 hours prompting for toilet use, the record did not include a corresponding comprehensive bowel/bladder assessment that would identify the appropriateness of the intervention of either every one hour or two hours to meet R20's individualized toileting needs. During an interview on 4/9/25 at 1:17 p.m., director of nursing (DON) stated R22's medical record did not identify a comprehensive analysis of his falls nor identify a root cause of the falls. DON further stated a root cause analysis work sheets had not been consistently completed for each fall to better determine the root cause of falls and ensure appropriate fall prevention interventions were in place.	F 689		

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F 689	Continued From page 14 Review of the facility's Fall Prevention Program undated, identified each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. -The nurse will indicate on the (area left blank) the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. The nurse will refer to the facility's High Risk of Low/Moderate Risk protocols when determining primary interventions. -High Risk Protocols: -Indicate fall risk on care plan. -Place fall prevention indicator (such as star, color coded sticker) on the name plate to resident's room. -Place fall prevention indicator on resident's wheelchair.	F 689		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		5/13/25

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F 880	Continued From page 15 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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 16 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 implement infection control strategies for respiratory protection to mitigate the risk and spread of Respiratory Syncytial Virus (RSV- an infection of the respiratory tract). As a result, the facility developed an outbreak where 8 residents (R10, R13, R14, R11, R12, R17, R6, and R16) tested positive for RSV and 3 residents were suspected to have RSV (R15, R7, R18); 2 residents (R10 and R12) were seen in the emergency department (ED) and 3 residents (R11, R13, and R14) were hospitalized at a higher level of care. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility resulting in an immediate jeopardy (IJ) which placed all residents at a high likelihood of serious illness and/or death by contracting a communicable respiratory disease. The Immediate Jeopardy (IJ) began on 3/16/25 when R10 tested positive for RSV and the facility failed to implement infection control strategies to	F 880	F880: 1. Corrective action will be accomplished for the residents as follwed: Olivia Restorative Therapy and Nursing has created a process for nurses to implement screening and monitoring of residents with illnesses including respiratory illness. Facility has created a procedural list for nursing to follow for implementation of illness monitoring and documentation active screening tools and monitoring tools for illness onset and notify the provider for the residents, implementation and removal of isolation precautions, contact tracing forms for staff and residents, and implemented procedures for mitigating spread of transmittible illnesses. Olivia Restorative Therapy and Nursing has educated staff on new processes, staff illnesses, hand hygiene, and Personal Protective Equipment. Education was sent out via text and email to Education was sent out on 4/4/2025 for	

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OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE AVENUE OLIVIA, MN 56277

(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 880	Continued From page 17 mitigate the risk and spread of RSV in the facility. The Administrator and director of nursing (DON), were notified of the IJ on 4/4/25 at 3:30 p.m. The IJ was removed on 4/8/25 at 6:32 p.m., but noncompliance remained at the lower scope and severity level F, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include: Definitions: Isolation: Isolation separates sick people with a contagious disease from people who are not sick. Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. Personal protective equipment (PPE): Personal protective equipment (PPE) refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. These items may include a gown, gloves, eye protection and face mask. Enhanced barrier precautions (EBP): refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Gowns and gloves are used as PPE. Transmission based precautions (TBP): refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact, and droplet) to prevent or control infections. Airborne,	F 880	completion within 24 hours. The knowledge test of information sent out on 4/5/25 to have staff complete within 24 hours. DON or designee will assess staff knowledge to prove them to understand the information. Audits will be conducted daily throughout the outbreak to assure adherence to proper personal protective equipment usage and Hand Hygiene. The action will be completed on 4/5/2025. 2. In the Olivia Restorative Therapy and Nursing, 3 residents have suffered from a transmittible illness resulting in hospitalization. All other residents have potential to be affected.¿ 3. The DON or designee could educate all staff on existing or revised policies and perform ongoing continuous audits to ensure compliance on April 15th, 2025. 4. Audits by floor nurses will be conducted daily throughout the outbreak to assure adherence to proper personal protective equipment usage and Hand Hygiene. The action will be completed on 4/5/2025. The Director of Nursing (DON), ICP, or designee will review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE to wear. Environmental rounds and audits, and re-education anytime EBP are placed The DON, ICP or designer could take those findings/education to the Quality Assurance Performance Improvement	

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F 880	Continued From page 18 contact, and droplet are the three subcategories under TBP. Contact precautions: refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Use with gloves, and gowns as PPE. Droplet precautions: refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions, masks are used as PPE. Upon entrance to the facility on 4/1/25 at 11:15 a.m., there was no signage posted alerting that the facility had an RSV outbreak. Surveyor was informed the facility had one case of RSV in the building and resident (R12) was on precautions. This was observed on 4/1/25 at 11:54 a.m., of the south hallway with signage on R12's door. Trained medication aide (TMA)-F was using PPE when entering the room to administer medications. R10 symptom onset 3/16/25; positive RSV on 3/16/25 R10's face sheet dated 4/11/25, identified diagnoses of morbid (severe) obesity with hypoventilation, obstructive sleep apnea, heart failure, chronic obstructive pulmonary disease (COPD- lung diseases that cause persistent airflow obstruction and breathing difficulties). R10's record reviewed between 3/11/25 through 3/15/25 did not identify any symptoms of	F 880	(QAPI) committee. Audits will be completed daily x1 week, weekly x3, monthly x3 to assure continued compliance and reviewed QAPI with the involvement of facility Medical Director.¿ ¿ 5. Correction date: May 13, 2025	

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F 880	Continued From page 19 respiratory illness. R10's progress note dated 3/16/25 at 12:45 p.m., indicated R10 stated he was not feeling well and thinks he has COVID. Lung sounds with noted rhonchi (rattling lung sounds). COVID test performed with negative results. R10's medical record did not identify R10 was placed on isolation precautions (droplet/contact precautions) when respiratory symptoms were identified. R10's record did not indicate droplet/contact precautions were initiated at symptom onset. R10's progress notes dated 3/16/25 at 1:22 p.m., indicated R10 had not been feeling well for four days with coughing. R10's lung sounds with rhonchi and cough and R10 agreed to be sent to emergency department (ED). R10's hospital emergency department (ED) note dated 3/16/25, identified R10 was seen for evaluation for an ongoing cough over past few weeks and increasing shortness of breath. R10's ED record identified lung sounds to be diffuse rhonchi (sounds like snoring or gurgling) throughout and tested positive for RSV. R10's diagnoses at discharge from the ED included RSV bronchiolitis (swelling, irritation, and buildup of mucus in the small airway of the lung) and acute exacerbation of COPD. R10 discharged back to the facility with nebulizers and steroids. R10's progress note dated 3/16/25 at 4:56 p.m., identified paperwork from hospital reviewed and R10 diagnosis of RSV and COPD exacerbation. Staff updated on "airborne" (sic) precaution, reminded to wear masks, gloves, and wash hand. However, review of R10's record did not identify a physician order for precautions nor was TBP	F 880		

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F 880	Continued From page 20 identified in R10's care plan. R10's record reviewed between 3/17/25 through 4/4/25 did not identify ongoing symptom monitoring, isolation, transmission precautions, or removal of isolation. During an interview on 4/3/25 at 11:12 a.m., director of nursing (DON) stated if a resident is positive for RSV they are put on precautions and isolation and encouraged to wear a mask when coming outside of their room. DON stated they did not have any protocols for nurses to follow for monitoring residents for any symptoms to identify new cases immediately. DON confirmed facility had not done any active screening of residents to identify illness and had not completed comprehensive respiratory assessments for residents with suspected/confirmed RSV cases. During a subsequent interview on 4/4/25 at 11:11 a.m. DON confirmed R10 was removed from isolation on 3/23/25, R10 did not have a respiratory assessment to determine if symptoms resolved prior to removing from isolation, R10 was removed from isolation because he no longer needed nebulizer treatments. DON further stated after research on the Centers for Disease Control and Prevention (CDC) website for RSV, a resident should have been in isolation and precautions for ten days, however, the facility did not follow CDC guidelines and removed R10 at seven days. R13 symptom onset 3/25/25; positive on 4/3/25 R13's face sheet date 4/10/25, indicated diagnoses of dementia and weakness. R13's record between 3/16/25 through 3/26/25	F 880		

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F 880	Continued From page 21 did not identify any respiratory symptom screening, even though the facility had RSV cases. R13's progress note dated 3/27/25, identified R13 complained of sore throat for two days. R13 was given cough drop and COVID test performed with negative results no other tests were completed. R13's progress noted dated 3/30/25, identified R13 received cough syrup for cough. R13's progress note dated 4/2/25 at 12:37 a.m., identified R13 was coughing with congestion and feeling cold/chills. At 3:56 p.m. R13 was feeling weak and complaining not feeling good. Lung sounds wheezing with crackles was coughing with congestion and feeling cold and chills. R13 was given a nebulizer with no relief. R13 was placed on oxygen. Physician notified of change in condition and recommendation to monitor in facility and will reassess next day. R13's progress note dated 4/3/25 at 9:50 a.m., identified R13 became short of breath (SOB) while on toilet and unable to stand. Oxygen was placed on R13 and given a nebulizer with oxygen saturations going as low as 80% (normal ranges are 92 to 100%). Provider was notified. At 10:28 a.m. R13 was seen by the nurse practitioner who ordered RSV test, antibiotics, and steroids. At 10:59 a.m. R13 was short of breath with low oxygen saturations and was sent to the ED. R13's record between 3/25/25 through 4/3/25, identified despite R13 demonstrated respiratory symptoms TBP was not implemented. During an observations on 4/1/25 through 4/3/25	F 880		

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F 880	Continued From page 22 at 11:00 a.m., R13 did not have TBP precaution signs on his door. During an observation and interview on 4/3/25 at 11:00 a.m., trained medication aide (TMA)-D came out of R13's room without PPE and stated R13 was being sent to ED due to difficulty breathing and possible RSV. TMA-D stated R13 had been sick since 3/30/25, and he complained of a sore throat and was not put on precautions or isolation when he developed symptoms. During an interview on 4/3/25 at 11:21 a.m., registered nurse (RN)-B stated R13 was sent by ambulance for possible RSV. RN-B stated R13's roommate, R14 was in the hospital for unknown reason. RN-B also stated the facility had three known cases of RSV, R10, R11 and R12. RN-B stated R12 was the only resident currently on isolation for RSV in the facility. RN-B stated if a resident became symptomatic a comprehensive respiratory assessment should be completed daily, however a nursing order was not in the charts to direct staff on what to monitor for. RN-B further stated symptomatic residents should be put on droplet precautions, notify physician, and tested for RSV. R13's ED hospital record dated 4/3/25, indicated R13 was seen in ED for shortness of breath. R13 required supplemental oxygen to maintain oxygen level greater than 92%. R13 indicated that he had not been feeling well for the past 3 weeks. R13 lung sounds revealed right and left wheezing through with decreased lung sounds in right middle and bilateral lower fields. R13's heart rate was 90-150 (normal range is 60 - 100) with no known history of atrial fibrillation. R13 was admitted to the local hospital and started on	F 880		

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F 880	Continued From page 23 intravenous antibiotics (IV) and IV cardiac medications were started also. R13 tested positive for RSV and was transferred to higher level of care for further care with diagnoses of respiratory failure, sepsis, and Atrial fib with rapid ventricular response. R13 returned to the facility on 4/7/25, with hospital diagnoses of pneumonia of right lower lobe due to infectious organism and was started on oral antibiotics. R14 symptom onset 3/25/25, positive for RSV on 4/1/25 R14's face sheet dated 4/10/25, indicated diagnoses of CHF and chronic respiratory failure with hypoxia. R14's record between 3/16/25 through 4/1/25 did not identify any respiratory symptom screening, even though the facility had RSV cases. R14's progress notes dated 3/8/25, identified R14 required continuous oxygen to keep saturations greater than 90%. R14's progress notes dated 3/25/25, identified R14 had complaints of not being able to breathe from his nose being stuffy, however R14's medical record did not identify implementation of TBP when symptoms identified. R14's progress notes dated 4/1/25, R14 received two puffs of albuterol inhaler (medication to help open airway) as R14 was struggling to breathe, wheezing and had congestion. R14 had chills and was shaking. Vital signs were blood pressure 155/104 (normal is less than 120/80), pulse 105, respirations 22 (normal range is 12-22) and oxygen saturations 72% on three liters of oxygen.	F 880		

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F 880	Continued From page 24 R14 was transported to local ED via ambulance. R14's hospital ED note dated 4/1/25, indicated R14 presented per ambulance, unresponsive after sudden onset of shortness of breath. R14's lung sound indicated chest lung congestion bilaterally with mottling (bluish/graying skin color meaning lack of oxygen). R14 was intubated emergently (a tube is inserted into the trachea to help person breathe). R14's temperature was 103 degrees (normal is 96.4 to 98.6). R14 was tested positive for RSV and was transferred via air ambulance to higher level of care with diagnoses of septic shock (a life-threatening condition) and acute respiratory failure. R14's hospital pulmonology noted dated 4/2/25, identified R14 was on mechanical ventilation and had a diagnosis of acute on chronic hypoxemic hypercapnic respiratory failure -improving and RSV pneumonia complicated by left lower lobe pneumonia. R14's progress notes dated 4/3/25, identified social worker at hospital called and R14 was sedated, on a ventilator, and positive for RSV. R14's hospital note dated 4/9/25, R14 remained at a higher level of care, on three liters of oxygen, with no return dated noted. During an interview on 4/3/25 at 1:00 p.m., DON stated R14 was in the hospital for aspiration pneumonia but had been negative for RSV. During an interview on 4/4/25 at 10:58 a.m., assistant director of nursing/infection preventionist (ADON -IP) stated she was not aware of R14's positive RSV test result until	F 880		

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F 880	Continued From page 25	F 880		

4/3/25 after looking at the hospital records. ADON-IP stated R14's onset of RSV began on 4/1/25 with the positive test and was unaware of symptom onset of a stuffy nose on 3/25/25.

R11 symptom onset 3/28/25, positive 3/28/25

R11's face sheet dated 4/10/25, indicated diagnoses of congestive heart failure (condition where heart does not pump as well as it should), respiratory failure (condition where the lungs are unable to adequately exchange gases, resulting in either insufficient oxygen intake and/or inadequate carbon dioxide removal) with hypoxia (lack of oxygen), and morbid obesity.

R11's record between 3/16/25 through 3/28/25 did not identify any respiratory symptom screening, even though the facility had RSV cases. R11's record did not identify R28 had symptoms prior to 3/28/25.

R11's progress note dated 3/28/25 at 1:32 p.m., identified R11 was not feeling well after 12:00 p.m., and appeared to be shaky, unable to transfer self, and needed supplemental oxygen, and 911 was called. Note at 2:16 p.m., identified R11 was transferred to hospital via ambulance.

R11's progress note dated 3/28/25 at 4:44 p.m., identified hospital called and R11 had tested positive for COVID and RSV.

R11's hospital ED note dated 3/28/25, indicated R11 presented via EMS for evaluation of difficulty breathing, shaking, nausea, tachycardia, and low blood pressure. Heart rate in 140's with oxygen sats in the 70's and temperature of 100.4. R11's lung sounds were decreased with wheezing and

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F 880	Continued From page 26 rales present. R11 was transferred to higher level of care due to hypoxia secondary to new diagnosis of RSV and COVID. R11's progress notes dated 4/7/25, indicated R11 remained in ICU, was hallucinating, and was restless and needing supplemental oxygen at 4 liters per nasal cannula. R12 symptom onset 3/31/25, positive 3/31/25 R12's face sheet dated 4/10/25, indicated diagnoses of cancer of the prostate, CHF and dementia. R12's record between 3/16/25 and 3/30/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 3/31/25. R12's progress notes dated 3/31/25, indicated R12 was showing decline in health, slightly diaphoretic (sweaty) and slightly elevated blood pressure. R12 was sent to ED for evaluation. R12's ED progress notes dated 3/31/25, indicated R12 was seen in ED following a fall and had mentation changes. R12 had a cough and nursing home staff reported increased lethargy. R12's assessment indicated a congested cough with rhonchi (abnormal lung sounds caused by secretions or obstruction of airway) in left lower lobe. R12 tested positive for RSV in ED and was discharged back to the nursing home by private vehicle. R12's progress note dated 3/31/25 at 3:01 p.m., identified R12 returned to facility with a diagnosis of RSV. R12's record did not identify if and when	F 880		

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F 880	Continued From page 27 TBP were implemented after return from ED. R12's progress notes from 3/31/25 through 4/8/25 lacked an ongoing symptom monitoring and utilization of TBP. During an observation on 4/1/25 at 5:07 p.m., R12 was noted in the hallway outside conference room without a mask on. Three staff walked by him. Nursing assistant (NA)-P stopped, applied gloves, and turned R12's wheelchair around, explained to R12 he needed to stay in his room as he was sick. NA-P was not wearing a mask and did not apply or offer one to R12 as he took him back to his room. During an observation on 4/3/25, at 5:12 p.m., approximately 15 residents were eating in the main dining room, 3-5 residents per table, without masks on. Resident were seated two to three feet apart. R12, who was RSV positive on 3/31/25, was seated a few feet from R15, neither one had mask on. Multiple staff were in the dining room, serving the meals and did not identify R12 should have been eating in his room. DON entered dining room and applied a mask to R12 and walked him out to his room from the main dining room. DON stated R12 should have been eating in his room and not in the main dining room. During an interview on 4/3/25 at 5:25 p.m., NA-H stated R12 was supposed be eating in his room due to RSV, and if staff noticed him coming out of his room, staff walked him back to his room. During an interview on 4/4/25 at 10:58 a.m., ADON-IP stated she was not employed in the facility when the first case of RSV was detected and had not implemented contact tracing since	F 880		

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F 880	Continued From page 28 she had started, however had started a map of the positive cases. ADON was not aware how many cases constituted an outbreak, but thought it was three or more. R12, R13, and R14 all ate meals together and she believed this was part of the spread and had just made that determination today on 4/4/25. If residents were exposed to another positive resident who had RSV they should have been kept in isolation, monitored closely for symptoms, and tested if symptoms develop. R17 symptom onset 4/4/25; positive for RSV on 4/9/25 R17's face sheet dated 4/10/25, indicated diagnoses of diabetes, paraplegia (paralysis of the legs and lower body), and diabetes. R17's record between 3/16/25 through 4/7/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/4/25. R17's progress note dated 4/4/25, R17 had reported he did not feel good but was not ill. R17's record did not include respiratory assessments until 4/8/25. R17's record did not identify a respiratory assessment/screener between 4/5/25 to 4/7/25. R17's progress note dated 4/8/25, indicated R17 had cough with congestion. However, the record indicated R17 was not tested for respiratory illness until 4/9/25. R17's laboratory report dated 4/9/25, indicated R17 tested positive for RSV.	F 880		

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F 880	Continued From page 29 R6 symptom onset 4/6/25; positive for RSV on 4/9/25 R6's face sheet dated 4/10/25, indicated diagnoses of cerebrovascular accident (stroke), hemiplegia or hemiparesis (weakness on one side of the body). R6's record between 3/16/25 and 4/5/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/6/25. R6's progress note dated 4/6/25 at 8:45 p.m., R6 requested an RSV test as he was having a sore throat and raspy voice. R6's progress note dated 4/8/25, identified R6 was on quarantine due to unspecified outbreak. R6's progress notes dated 4/9/25, identified lab results received by facility and tested positive for RSV. R16 symptom onset 4/7/25; positive for RSV on 4/9/25 R16's face sheet date 4/10/25, indicated diagnoses of CHF, Parkinson's Disease (a progressive neurological disorder characterized by gradual loss of nerve cells in the brain, leading to tremors, slow movements, and rigidity), obstructive sleep apnea, myasthenia gravis an autoimmune disorder) and respiratory failure. R16's record between 3/16/25 and 4/6/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/7/25. R16's progress note on 4/7/25 identified R16 had	F 880		

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F 880	Continued From page 30 developed a cough with wheezing. R16 was placed on precautions and tested. R16's laboratory results dated 4/9/25, indicated R16 tested positive for RSV. R15 symptom onset 4/7/25 R15's face sheet dated 4/10/25, indicated diagnoses of chronic viral hepatitis C and sheltered homelessness. R15's record between 3/16/25 and 4/6/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/7/25. R15's progress note 4/7/25, identified R15 had developed sore throat. R15's laboratory report dated 4/9/25, indicated R15 tested negative for RSV, COVID and influenza. R7 symptom onset 4/8/25 R7's face sheet dated 4/10/25, indicated diagnoses of multiple sclerosis (MS- a chronic autoimmune disease that affects the brain and spinal cord). R7's record between 3/16/25 and 4/7/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/8/25. R7's progress notes dated on 4/8/25, R7 had developed a sore throat, and hoarse voice. R7's laboratory results dated 4/9/25, indicated R7 tested negative for RSV, COVID and influenza.	F 880		

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F 880	Continued From page 31 R18 symptom onset 4/8/25 R18's face sheet dated 4/10/25, indicated diagnoses of obstructive sleep apnea. R18 ' s record between 3/16/25 and 4/7/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/8/25. R18's progress notes dated 4/8/25, R18 was noted to be coughing, stated it was his normal and respiratory assessment completed without any other symptoms noted. R18 was put on droplet/contact precautions, however refused to be tested for COVID, influenza and RSV. During an interview on 4/4/25 at 8:57 a.m., licensed practical nurse (LPN)-B stated monitoring for respiratory symptoms would include lung sounds, looking for symptoms like runny nose or cough. If new symptoms were found then the provider would be notified, the resident tested, and precautions put into place. LPN-B was not aware of any symptom monitoring being done for any residents at this time and this should be done. During an interview on 4/3/25 at 3:24 p.m., registered nurse (RN)-B stated if staff call in sick with respiratory symptoms, they would be asked to test for COVID, however, if negative then it must just be a cold, and could work while wearing a mask. If a resident became symptomatic then staff would test and monitor symptoms, however, was not aware if the facility was doing that. RN-B stated she believed full facility masking and monitoring of all the residents for symptoms of	F 880		

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F 880	Continued From page 32 RSV should have been initiated after the first case of RSV was in the facility. During an interview on 4/3/25 at 1:00 p.m., DON stated if there was a respiratory outbreak, the following would need to be initiated: staff masking, encourage resident masking, reduce the number of residents in activities, and limit numbers in dining room for meals. However, none of these activities had been done at this time, due to not identifying the cases of RSV as an outbreak. DON also stated not all the RSV cases had been added to a surveillance log to track the cases. DON stated a map of the cases in the facility had not been completed at this time to allow the facility track trend the infection. Staff illness was tracked, and no cases of respiratory illness had been identified. During an interview on 4/4/25 at 10:31 a.m., medical director (MD)-A stated was not aware of the facility's RSV outbreak until 4/3/25. His expectations during a respiratory outbreak would be for the facility to follow their policies on infection control/respiratory illnesses, notify the medical director, and follow recommendations from CDC/MDH on TBP. Any type of respiratory illness with a resident with other contributing factors, such as COPD, could lead to the likelihood of serious harm, impairment, or even death. The immediate jeopardy that began on 3/16/25, was removed on 4/8/25. when it was verified, the facility implemented the following: -Facility provided education to all staff pertaining to PPE, implementation and removal of TBP, physician notification, active screening, and staff illness.	F 880		

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F 880	Continued From page 33 -Facility updated the surveillance log -Facility implemented and developed a tracking log for staff illness. -Facility developed screening and monitoring tools for respiratory illnesses. -Facility developed and implemented a process for implementing and removing TBP's and physician notification. -Facility developed and implemented a process for testing residents. -Facility identified high risk exposures to RSV and placed those residents on isolation, -Facility implemented active screening on all residents to identify early symptoms and implemented TBP as applicable. -Implemented mask use for staff and visitors. -Facility provided education to all staff pertaining to PPE, implementation and removal of TBP, physician notification, active screening, and staff illness. -Facility updated the surveillance log -Facility implemented and developed a tracking log for staff illness. Review of facility's Infection Outbreak Response and Investigation Policy undated, identified an outbreak generally refers to the occurrence of more cases of a communicable disease than expected in a given area or among a specific group of people over a particular period of time. If a condition is rare or has serious health implications, an outbreak may involve only one case. Prompt recognition of an outbreak: The following triggers shall prompt an investigation as to whether an outbreak exist: -A sudden cluster of infections in a unit or during a short period of time. -A single case of a rare or serious infection.	F 880		

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F 880	Continued From page 34 Implementation of infection control measures: -symptomatic residents will be considered potentially infected, assessed for immediate need, and placed on empiric precautions while awaiting physician orders. -symptomatic employees will be screened by the Infection Preventionist/or designee. -In the event of a known communicable disease outbreak, the facility should screen visitors for signs and symptoms of the communicable disease in accordance with national standards. -Transmission based precautions will be implemented as indicated for the particular organism. -Surveillance activities will increase to daily for the duration of the outbreak. Outbreak investigation: -Last page was not provided Review of facilities undated and unsigned, Transmission Based (Isolation Precautions) Type and Duration of transmission-Based Precautions Recommended for Selected Infections and Conditions, chart dated 2024, indicated for RSV infection in immunocompromised adults, contact precautions was needed for duration of illness and to wear a mask according to standard precautions. Review of facility policy, dated 3/24/25, Infection Prevention and Control Program, indicated the following: 3. Surveillance: a. a system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteer, visitors, and other individuals providing services under a contractual arrangement based upon a facility	F 880		

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F 880	Continued From page 35 assessment and accepted national standards. c. The registered and licensed practical nurses participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in house reporting of communicable diseases and infections. 13. Resident/Family/Visitor Education and Screening a. Residents, family members and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff. 19. Respiratory Illness Reporting: a. The facility must input the following information into the NHSN reporting module weekly: 3. confirmed resident cases of COVID 19, influenza, and RSV; 4. hospitalized residents with confirmed cases of COVID 19, influenza, and RSV (overall and by vaccination status).	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 4/1/25 thru 4/4/25, and 4/8/25 and 4/9/25 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52901666C (MN00111541), H52909781 (MN00111297), H52902130C (MN00111710 and MN000111797), H52902350C (MN00111846,were incompliance: H52902685C (MN00112052) with licensing orders issued at 0830 and 1375. 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	2 000		

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2 000	Continued From page 2 electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess falls for root cause, revise the care plan and implement appropriate interventions to prevent and/or reduce the risk of falls with major	2 830	Corrected. May 13, 2025	5/13/25

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2 830	Continued From page 3 injury for 2 of 3 residents (R20, R22) who had falls. This resulted in an immediate jeopardy for R20 who had a history of traumatic brain injuries and sustained a fall that resulted in a subdural hematoma and was hospitalized. The IJ began on 3/28/25 after R20 had a fall, the facility failed to assess and implement appropriate interventions to prevent/mitigate risk for falls which resulted in R20's fall on 4/4/25 in which R20 suffered an intercranial brain injury and hospitalization. The Administrator, director of nursing (DON) were notified of the IJ on 4/8/25 at 6:32p.m. The immediate jeopardy was removed on 4/9/25 at 4:40 p.m., but non-compliance remained at the lower scope and severity level D, which indicated no actual harm with the potential for more that minimal harm that is not immediate jeopardy. Findings include: R20's face sheet dated 4/9/25, identified R20 was admitted on 3/26/25 with diagnoses including subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), fracture of skull, and intracranial injury. R20's Brief Interview for Mental Status (BIMS) dated 3/27/25 identified R20 had severe cognitive impairment. R20's fall risk assessment dated 3/26/25, identified R20 was high risk which identified risk factors of disorientation at all times; three or more falls in the past three months; poor vision; balance problem while walking; requires assistive device; and required 1-2 medications that could cause lethargy or confusion. The report also identifed R20 had 1-2 predisposing diseases that	2 830		

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2 830	Continued From page 4 increased R20's risk for falls but did not specify which pertained; the listing of risk diagnoses included circulatory, neuromuscular/functional, orthopedic, perceptual, psychiatric/cognitive, infection, pain/headache, fatigue/weakness, weight loss, vitamin D deficiency and history of falls. R20's progress note dated 3/26/25, director of nursing (DON) identified R20 was admitted with multiple facial fractures and a traumatic brain injury. Report from the hospital said his blood pressure runs low most of the time, does not remember this and gets up alone, wanders outside of his room, and goes to the bathroom alone. R20's progress note dated 3/27/25 at 11:07 a.m., identified R20 can use the bathroom independently. R20's progress note dated 3/28/25 at 12:57 a.m., identified R20 was independent with toileting, transfers, and ambulating. R20's record between 3/26/25 through 4/3/25 did not include a care plan for falls despite R20's high risk for falls identified on the fall risk assessment completed on 3/26/25. R20's unwitnessed fall incident report dated 3/28/25 at 6:00 a.m., identified R20 was found sitting on the floor by his bathroom. Intact range of motion. Denied pain and alert and oriented x 1 with some confusion. Unable to use the call light. R20 was given gripper socks which he had taken off. Staff to check often (frequency not specified). The report did not identify if R20 was incontinent and/or he was attempting to use the toilet. Although the report identified potential causal/risk	2 830		

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2 830	Continued From page 5 factors of confusion, unable to use the call the call light, and had taken off gripper socks, the report did not include a comprehensive fall analysis. The report indicated on 3/31/25 the facility developed a fall intervention to add a soft touch call light and gripper socks. However, R20's care plan did not identify R20's high risk for falls or include the interventions of soft touch call light, gripper socks, and staff to check often. Further, R20's record did not include a comprehensive assessment that identified the level or frequency of supervision that corresponded with the intervention of "staff to check often". R20's progress note dated 3/29/25 at 11:52 a.m., included R20 had wandered into hallway three times and needed to be redirected back to room. R20's physical therapy noted dated 3/31/25, included R20 was a fall risk and ambulates to the bathroom without asking for assistance. R20 was educated on the call light and coordination with nursing. The note did not identify what was coordinated with nursing. R20's unwitnessed fall incident report dated 4/1/25 at 10:00 p.m., identified nursing assistant went to check on resident per nurse request and R20 was found on floor by television. R20 "was towards the door" and head by the bedside table with head of bed elevated. R20 stated he missed his bed walking backwards. No other information was included. R20's record did not include a comprehensive fall assessment/analysis that identified probable causal factors/root cause with corresponding individualized interventions to prevent and/or mitigate the risk of falls. Interventions that were identified included room was re-arranged and bed moved against the wall	2 830		

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2 830	Continued From page 6 and frequent (was not specified) checks at night initiated. However, R20's care plan for falls was not developed (there was no care plan) and the record did not include a comprehensive assessment that identified the level or frequency of supervision that corresponded with the intervention "frequent checks" at night. R20's progress note dated 4/4/25 at 4:25 a.m. indicated R20 had an unwitnessed fall in his room. Staff heard a loud noise and found R20 leaning on the wall by the television. R20 reported he hit his head and was complaining of pain in both lower and upper extremities, R20 was given Tylenol, vital signs were taken. and he was sent to the emergency room (ER) R20's hospital imagining report dated 4/4/25, identifed a head computed tomography (CT) was performed following a fall with head injury with a critical result of a new intercranial hemorrhage or herniation. R20's hospital emergency department to hospital discharge summary dated 4/5/25, identified R20 admitted to hospital on 4/4/25 to 4/5/25, following a fall and was noted to have a subdural hematoma on computed tomography (CT) scan. R20 was discharged back to facility on 4/5/25. R20's unwitnessed fall incident report dated 4/4/25 at 4:20 a.m., identified a loud noise heard from room and R20 found leaning on the wall by the television. R20 stated he hit his head and complaining of pain in ribs and left arm. R20 sent to emergency room for evaluation. R20's record did not include a comprehensive fall assessment/analysis that included potential causal factors/root cause for the development of individualized interventions to prevent or mitigate	2 830		

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2 830	Continued From page 7 the risk of falls and/or falls with major injury. Additionally, no additional fall interventions were documented in the fall report. R20's progress note dated 4/5/25, identified R20 returned to facility after being sent to the hospital following a fall and sustaining a subdural hematoma and report from the hospital there will be no changes. Review of R20's record did not identify the care plan was revised/updated upon or after R20's return from the hospital. R20's progress note dated 4/7/25 at 9:09 a.m., identified R20 was walking to the bathroom and staff witnessed R20 falling by his closet door, and he was then assisted to ground. R20 had been seen less than 15 minutes before the fall. R20 reported he became dizzy while self-transferring. R20 was wearing gripper socks. Immediate intervention was orthostatic blood pressures and prompted to use the toilet. Pharmacy was notified for medication review. Review of R20's physician orders/treatments identified the directive to obtain orthostatic blood pressure was not transcribed until 4/8/2025. Additionally, review of R20's record did not identify a comprehensive analysis for causal factors/root cause. Further, R20's record identified although the care plan had been revised on 4/8/25 to include every 1-2 hours prompting for toilet use, the record did not include a corresponding comprehensive bowel/bladder assessment that would identify the appropriateness of the intervention to meet R20's individualized toileting needs. Although the facility developed and implemented R20's fall care plan on 4/4/25, the care plan did not include the interventions of 'soft touch call light', and 'staff to check often' that were identified on 3/28/25 fall report and did not include 'frequent	2 830		

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2 830	Continued From page 8 checks at night' and bed up against the wall that was identified on the 4/1/25 fall report. R20's fall focus care plan initiated on 4/4/25, identified R20 was high risk for falls related to unspecified intracranial injury, anxiety disorder, traumatic subarachnoid hemorrhage, atrial fibrillation and incontinence. R20 will often get up on his own, not use the call light to alert staff even with numerous staff reminders and encouragement. Interventions included: anticipate resident's needs, be sure call light is within reach and encourage to use it for assistance, prompt responses for all requests for assistance, and ensure wearing appropriate non-slip/non-skid footwear when ambulating or mobilizing in wheelchair. During an interview on 4/8/25 at 10:15 a.m., nursing assistant (NA)-K stated R20 did not use his call light and has attempted to self-transfer many times since admission due to being confused at times. Staff have been doing frequent checks, however at times when NA-K was busy assisting other residents he could not check on R20 as frequently as he should. NA-K also stated R20's care plan did not identify a timeframe of how often the frequent checks should be done. NA-K explained frequent checks means for staff to "just look in [R20's] room" to see what he was doing, NA-K was unable to define the time frame of "frequent checks" as the care plan was not specific. NA-K indicated he thought there was a form for R20's "checks" staff were supposed to complete, however, was not aware of the location of where it was kept so had not completed the form. During an interview on 4/8/25 at 10:50 a.m., trained medication aide (TMA)-D stated since admission R20 will self-transfer and had been	2 830		

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2 830	Continued From page 9 found wandering in the hallway; staff would then assist him back to his room. Staff check on R20 often to ensure he was not self-transferring. TMA-D further explained to her "check often" meant look in R20's room every time she would passed by. TMA-D could not define a specific timeframe of how often checks were supposed to be completed and was not aware how often staff pass by R20's room. TMA-D was unaware of any other fall interventions in place for R20. During an interview on 4/8/25 at 11:12 a.m., licensed practical nurse (LPN)-C stated R20 would self-transfer to the bathroom on his own without asking for help. LPN-C stated a visual every 15-minute paper checklist was implemented for R20 on 4/8/25, it was kept in a binder at the nurse's station. LPN-C reviewed the checklist for 4/8/25 and noted the checks were not consistently completed so far today (4/8/25). LPN-C then reviewed the care plan and noted the intervention for every 15-minute checks was not identified on R20's care plan. During an interview on 4/9/25 at 12:57 p.m., registered nurse (RN)-C stated she completed the care plans for all of the residents in the facility upon admission. RN-C verified R20's admission fall risk assessment identified him as a high fall risk and that R20's fall risk care plan had not been initiated until ten days after admission. RN-C indicated fall causal analysis was completed by the interdisciplinary team (IDT). RN-C used to be a part of that team but no longer was. When she was part of the team she would assist in determining the appropriate interventions and then would add them to the care plan. During a phone interview on 4/4/25 at 12:38 p.m., emergency room medical doctor (MD)-H reported	2 830		

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2 830	Continued From page 10 concerns pertaining to falls. R20 had been seen in the emergency department (ED) due to a fall in the facility and sustained a subdural hematoma and needed to be transferred to another hospital for further evaluation. During an interview on 4/9/25 at 4:23 p.m., certified nurse practitioner (CNP) stated R20 was "extremely elevated risk for falls" due to confusion and ability to transfer independently. CNP's expectation would have been for the facility to put fall prevention interventions in place on admission to the facility. CNP also stated due to R20's history of previous brain injuries prior to admission with any future falls with head injury could have the likelihood of serious injury, harm, impairment or even death. During an interview on 4/8/25 at 12:40 p.m., director of nursing (DON) identified R20 did not have a fall prevention care plan until after his fall on 4/4/25. DON stated R20 should have had a baseline care plan completed during the first forty-eight hours to identify his fall risk and had interventions in place at admission. DON also stated a comprehensive assessment of his falls, causal analysis, or root case of the falls to add appropriate interventions to prevent further falls had not been completed for any of R20's falls and should have been done. The IJ began on 3/28/25. was removed on 4/9/25 at 4:40 p.m., when it was verified, the facility implemented the following: 1. Facility reviewed and revised fall program and policies to define protocols for documentation with new templates developed and implemented. The revisions included role/responsibilities for the IDT. 2. Facility provided education with knowledge	2 830		

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2 830	Continued From page 11 check to nurses on the fall program process, completing the falls checklist, completing the implemented documentation, implantation of interventions, reviewing the effectiveness of the intervention, and updating the care plan. A knowledge test was attached to the fall education. 3. Facility provided education NAs on care plan and roles in the facility's fall program. 4. Facility provided education to IDT on roles and responsibilities pertaining to the fall program. 5. Facility reviewed R20's chart for fall incidences and fall analyzes. Care plan were reviewed and updated with fall interventions. Interdisciplinary team reviewed R20 to see if other modifiable risk factors can be implemented for resident. 6. Like residents were identified, facility completed comprehensive analysis, reviewed and revised care plans as appropriate. R22 R22's face sheet dated 4/10/25, identified R22 was admitted on 3/20/25 with diagnoses of fracture of right fibula, fracture of right rib, degeneration of nervous system, and schizoaffective disorder. R22's fall risk assessment dated 3/20/25, identified R22 was high risk for falls with 1-2 fall in past 3 months, chair bound, with predisposing disease or circulatory/heart, neuromuscular/functional, orthopedic, psychiatric/cognitive, infection, pain, weakness, and history of falls. R22's fall incident report dated 3/23/25 at 4:10 p.m., identified R22 was found on the floor next to his bed. R22 stated he was attempting to reach his remote to the television and slid from the bed. Incident report was not completed to include	2 830		

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2 830	Continued From page 12 mental status, predisposing physiological/environmental factors/situation factors. On 3/31/25 incident report identified new intervention of reached out to pharmacist of new recommendations. R22's care plan did not identify a fall focus care plan had been initiated, or any fall prevention interventions added. A post-fall root cause analysis worksheet was provided for R22's fall on 3/23/25, identified R22 was found on floor next to his bed, R22 was laying in bed watching television and dropped the remote and wanted to get it from the floor, call light was in reach, last toileted at 3:50 p.m., was not incontinent at time of fall, and had gripper socks on. Interventions put in place of frequent call light checks and request nursing assistants to check on resident often. Although the worksheet identified possible causal factors of the fall, no conclusion of the data was identified in the medical record to determine the root cause of the fall. R22's fall incident report dated 3/24/25 at 9:30 p.m., identified R22 was being assisted with transfer from bed to wheelchair and resident became weak and was lowered to the ground. Incident report was not completed to include mental status, predisposing physiological/environmental factors/situation factors. R22's care plan did not identify a fall care plan focus medical record did not identify comprehensive assessment, causal analysis, or root cause of the fall. R22's fall care plan focus dated 3/25/25, identified R22 was high risk for falls related to non-weight bearing of right foot, repeated falls, schizoaffective disorder bipolar type, spondylosis, inability to follow directions and impulsivity. Interventions included: anticipate and meet the	2 830		

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2 830	Continued From page 13 resident's needs, be sure call light is within reach and encourage and remind the resident to use it for assistance as needed. R22's activities of daily living (ADL) focus care plan dated 3/25/25, identified R22 required assist of two for all transfers and not able to follow directions for non-weight bearing of right foot. R22's consultant pharmacist review on 3/29/25, a medication review done due to frequent falls and recommended adjustments to fall risk medications. Review of R22's progress notes from 3/29/25 to 4/7/25 did not identify physician notification of consulting pharmacist recommendations until 4/8/25. R22's fall incident report dated 3/26/25 at 5:30 p.m., identified R22 was on floor sliding to the bathroom attempting to toilet himself. R22 was in bed prior to the fall and call light was on the bed. R22 was last toileted at 2:30 p.m., repositions self and had a large loose bowel movement. Fall mat was place on the floor and frequent checks to assure needs are met, and soft touch call light. R22's post-fall causal analysis worksheet dated 3/26/25, identified the aforementioned fall description and identified R22 was incontinent at time of fall. Although the worksheet identified possible causal factors of the fall including R22 was incontinent, no conclusion of the nor evident comprehensive assessment completed that addressed R22's toileting needs. Further R22's care plan did not identify the new interventions of fall mat, frequent checks, nor soft touch call light that were identified on fall report. Furthermore, R22's record identified although the care plan had been revised on 4/8/25 to include frequent checks-15 min checks. R22's record did not include a comprehensive assessment that identified the level or frequency of supervision	2 830		

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2 830	Continued From page 14 that corresponded with the intervention "frequent checks". R22's progress note dated 4/7/25, identified R22 was found sitting on the fall mat because he slipped due to slippery floor. R22 was coming back from bathroom. Immediate intervention to offer toileting every hour. R22's care plan was not revised on 4/7/25 to include offer toilet every hour. R22's record identified although the care plan had been revised on 4/9/25 to include every 2 hours prompting for toilet use, the record did not include a corresponding comprehensive bowel/bladder assessment that would identify the appropriateness of the intervention of either every one hour or two hours to meet R20's individualized toileting needs. During an interview on 4/9/25 at 1:17 p.m., director of nursing (DON) stated R22's medical record did not identify a comprehensive analysis of his falls nor identify a root cause of the falls. DON further stated a root cause analysis work sheets had not been consistently completed for each fall to better determine the root cause of falls and ensure appropriate fall prevention interventions were in place. Review of the facility's Fall Prevention Program undated, identified each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. -The nurse will indicate on the (area left blank) the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance	2 830		

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2 830	Continued From page 15 with the resident's level of risk. The nurse will refer to the facility's High Risk of Low/Moderate Risk protocols when determining primary interventions. -High Risk Protocols: -Indicate fall risk on care plan. -Place fall prevention indicator (such as star, color coded sticker) on the name plate to resident's room. -Place fall prevention indicator on resident's wheelchair. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure appropriate supervision and analaysis of falls occurs for fall prevention. The director of nursing or designee, should conduct measurable audits of fall to ensure analysis of the root cause if completed and identify if appropriate interventions are in place to prevent falls. The DON or designee should educate staff to those intervention. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		5/13/25

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21375	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement infection control strategies for respiratory protection to mitigate the risk and spread of Respiratory Syncytial Virus (RSV- an infection of the respiratory tract). As a result, the facility developed an outbreak where 8 residents (R10, R13, R14, R11, R12, R17, R6, and R16) tested positive for RSV and 3 residents were suspected to have RSV (R15, R7, R18); 2 residents (R10 and R12) were seen in the emergency department (ED) and 3 residents (R11, R13, and R14) were hospitalized at a higher level of care. The Immediate Jeopardy (IJ) began on 3/16/25 when R10 tested positive for RSV and the facility failed to implement infection control strategies to mitigate the risk and spread of RSV in the facility. The Administrator and director of nursing (DON), were notified of the IJ on 4/4/25 at 3:30 p.m. The IJ was removed on 4/8/25 at 6:32 p.m., but noncompliance remained at the lower scope and severity level F, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include: Definitions: Isolation: Isolation separates sick people with a contagious disease from people who are not sick. Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. Personal protective equipment (PPE): Personal	21375	Corrected. May 13, 2025	

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21375	Continued From page 17 protective equipment (PPE) refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. These items may include a gown, gloves, eye protection and face mask. Enhanced barrier precautions (EBP): refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Gowns and gloves are used as PPE. Transmission based precautions (TBP): refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission (airborne, contact, and droplet) to prevent or control infections. Airborne, contact, and droplet are the three subcategories under TBP. Contact precautions: refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Use with gloves, and gowns as PPE. Droplet precautions: refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions, masks are used as PPE. Upon entrance to the facility on 4/1/25 at 11:15 a.m., there was no signage posted alerting that the facility had an RSV outbreak. Surveyor was informed the facility one case of RSV in the building and resident (R12) was on precautions.	21375		

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21375	Continued From page 18 This was observed on 4/1/25 at 11:54 a.m., of the south hallway with signage on R12's door. TMA-F was using PPE when entering the room to administer medications. R10 symptom onset 3/16/25; positive RSV on 3/16/25 R10's face sheet dated 4/11/25, identified diagnoses of morbid (severe) obesity with hypoventilation, obstructive sleep apnea, heart failure, chronic obstructive pulmonary disease (COPD- lung diseases that cause persistent airflow obstruction and breathing difficulties). R10's record reviewed between 3/11/25 through 3/15/25 did not identify any symptoms of respiratory illness. R10's progress note dated 3/16/25 at 12:45 p.m., indicated R10 stated he was not feeling well and thinks he has COVID. Lung sounds with noted rhonchi (rattling lung sounds). COVID test performed with negative results. R10's medical record did not identify R10 was placed on isolation precautions (droplet/contact precautions) when respiratory symptoms were identified. R10's record did not indicate droplet/contact precautions were initiated at symptom onset. R10's progress notes dated 3/16/25 at 1:22 p.m., indicated R10 had not been feeling well for four days with coughing. R10's lung sounds with rhonchi and cough and R10 agreed to be sent to emergency department (ED). R10's hospital emergency department (ED) note dated 3/16/25, identified R10 was seen for evaluation for an ongoing cough over past few weeks and increasing shortness of breath. R10's	21375		

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21375	Continued From page 19 ED record identified lung sounds to be diffuse rhonchi (sounds like snoring or gurgling) throughout and tested positive for RSV. R10's diagnoses at discharge from the ED included RSV bronchiolitis (swelling, irritation, and buildup of mucus in the small airway of the lung) and acute exacerbation of COPD. R10 discharged back to the facility with nebulizers and steroids. R10's progress note dated 3/16/25 at 4:56 p.m., identified paperwork from hospital reviewed and R10 diagnosis of RSV and COPD exacerbation. Staff updated on "airborne" (sic) precaution, reminded to wear masks, gloves, and wash hand. However, review of R10's record did not identify a physician order for precautions nor was TBP identified in R10's care plan. R10's record reviewed between 3/17/25 through 4/4/25 did not identify ongoing symptom monitoring, isolation, transmission precautions, or removal of isolation. During an interview on 4/3/25 at 11:12 a.m., director of nursing (DON) stated if a resident is positive for RSV they are put on precautions and isolation and encouraged to wear a mask when coming outside of their room. DON stated they did not have any protocols for nurses to follow for monitoring residents for any symptoms to identify new cases immediately. DON confirmed facility had not done any active screening of residents to identify illness and had not completed comprehensive respiratory assessments for residents with suspected/confirmed RSV cases. During a subsequent interview on 4/4/25 at 11:11 a.m. DON confirmed R10 was removed from isolation on 3/23/25, R10 did not have a respiratory assessment to determine if symptoms resolved prior to removing from isolation, R10	21375		

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21375	Continued From page 20 was removed from isolation because he no longer needed nebulizer treatments. DON further stated after research on the Centers for Disease Control and Prevention (CDC) website for RSV, a resident should have been in isolation and precautions for ten days, however, the facility did not follow CDC guidelines and removed R10 at seven days. R13 symptom onset 3/25/25; positive on 4/3/25 R13's face sheet date 4/10/25, indicated diagnoses of dementia and weakness. R13's record between 3/16/25 through 3/26/25 did not identify any respiratory symptom screening, even though the facility had RSV cases. R13's progress note dated 3/27/25, identified R13 complained of sore throat for two days. R13 was given cough drop and COVID test performed with negative results no other tests were completed. R13's progress noted dated 3/30/25, identified R13 received cough syrup for cough. R13's progress note dated 4/2/25 at 12:37 a.m., identified R13 was coughing with congestion and feeling cold/chills. At 3:56 p.m. R13 was feeling weak and complaining not feeling good. Lung sounds wheezing with crackles was coughing with congestion and feeling cold and chills. R13 was given a nebulizer with no relief. R13 was placed on oxygen. Physician notified of change in condition and recommendation to monitor in facility and will reassess next day. R13's progress note dated 4/3/25 at 9:50 a.m., identified R13 became short of breath (SOB)	21375		

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21375	Continued From page 21 while on toilet and unable to stand. Oxygen was placed on R13 and given a nebulizer with oxygen saturations going as low as 80% (normal ranges are 92 to 100%). Provider was notified. At 10:28 a.m. R13 was seen by the nurse practitioner who ordered RSV test, antibiotics, and steroids. At 10:59 a.m. R13 was short of breath with low oxygen saturations and was sent to the ED. R13 ' s record between 3/25/25 through 4/3/25, identified despite R13 demonstrated respiratory symptoms TBP was not implemented. During an observations on 4/1/25 through 4/3/25 at 11:00 a.m., R13 did not have TBP precaution signs on his door. During an observation and interview on 4/3/25 at 11:00 a.m., trained medication aide (TMA)-D came out of R13's room without PPE and stated R13 was being sent to ED due to difficulty breathing and possible RSV. TMA-D stated R13 had been sick since 3/30/25, and he complained of a sore throat and was not put on precautions or isolation when he developed symptoms. During an interview on 4/3/25 at 11:21 a.m., registered nurse (RN)-B stated R13 was sent by ambulance for possible RSV. RN-B stated R13's roommate, R14 was in the hospital for unknown reason. RN-B also stated the facility had three known cases of RSV, R10, R11 and R12. RN-B stated R12 was the only resident currently on isolation for RSV in the facility. RN-B stated if a resident became symptomatic a comprehensive respiratory assessment should be completed daily, however a nursing order was not in the charts to direct staff on what to monitor for. RN-B further stated symptomatic residents should be put on droplet precautions, notify physician, and	21375		

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21375	Continued From page 22 tested for RSV. R13's ED hospital record dated 4/3/25, indicated R13 was seen in ED for shortness of breath. R13 required supplemental oxygen to maintain oxygen level greater than 92%. R13 indicated that he had not been feeling well for the past 3 weeks. R13 lung sounds revealed right and left wheezing through with decreased lung sounds in right middle and bilateral lower fields. R13's heart rate was 90-150 (normal range is 60 - 100) with no known history of atrial fibrillation. R13 was admitted to the local hospital and started on intravenous antibiotics (IV) and IV cardiac medications were started also. R13 tested positive for RSV and was transferred to higher level of care for further care with diagnoses of respiratory failure, sepsis, and Atrial fib with rapid ventricular response. R13 returned to the facility on 4/7/25, with hospital diagnoses of pneumonia of right lower lobe due to infectious organism and was started on oral antibiotics. R14 symptom onset 3/25/25, positive for RSV on 4/1/25 R14's face sheet dated 4/10/25, indicated diagnoses of CHF and chronic respiratory failure with hypoxia. R14's record between 3/16/25 through 4/1/25 did not identify any respiratory symptom screening, even though the facility had RSV cases. R14's progress notes dated 3/8/25, identified R14 required continuous oxygen to keep saturations greater than 90%. R14's progress notes dated 3/25/25, identified R14 had complaints of not being able to breathe	21375		

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21375	Continued From page 23 from his nose being stuffy, however R14's medical record did not identify implementation of TBP when symptoms identified. R14's progress notes dated 4/1/25, R14 received two puffs of albuterol inhaler (medication to help open airway) as R14 was struggling to breathe, wheezing and had congestion. R14 had chills and was shaking. Vital signs were blood pressure 155/104 (normal is less than 120/80), pulse 105, respirations 22 (normal range is 12-22) and saturations 72% on three liters of oxygen. R14 was transported to local ED via ambulance. R14's hospital ED note dated 4/1/25, indicated R14 presented per ambulance, unresponsive after sudden onset of shortness of breath. R14's lung sound indicated chest lung congestion bilaterally with mottling (bluish/graying skin color meaning lack of oxygen). R14 was intubated emergently (a tube is inserted into the trachea to help person breathe). R14's temperature was 103 degrees (normal is 96.4 to 98.6). R14 was tested positive for RSV and was transferred via air ambulance to higher level of care with diagnoses of septic shock (a life-threatening condition) and acute respiratory failure. R14's hospital pulmonology noted dated 4/2/25, identified R14 was on mechanical ventilation and had a diagnosis of acute on chronic hypoxemic hypercapnic respiratory failure -improving and RSV pneumonia complicated by left lower lobe pneumonia. R14's progress noted dated 4/3/25, identified social worker at hospital called and R14 was sedated, on a ventilator, and positive for RSV. R14's hospital note dated 4/9/25, R14 remained	21375		

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21375	Continued From page 24 at a higher level of care, on three liters of oxygen, with no return dated noted. During an interview on 4/3/25 at 1:00 p.m., DON stated R14 was in the hospital for aspiration pneumonia but had been negative for RSV. During an interview on 4/4/25 at 10:58 a.m., assistant director of nursing/infection preventionist (ADON -IP) stated she was not aware of R14's positive RSV test result until 4/3/25 after looking at the hospital records. ADON-IP stated R14's onset of RSV began on 4/1/25 with the positive test and was unaware of symptom onset of a stuffy nose on 3/25/25. R11 symptom onset 3/28/25, positive 3/28/25 R11's face sheet dated 4/10/25, indicated diagnoses of congestive heart failure (condition where heart does not pump as well as it should), respiratory failure (condition where the lungs are unable to adequately exchange gases, resulting in either insufficient oxygen intake and/or inadequate carbon dioxide removal) with hypoxia (lack of oxygen), and morbid obesity. R11's record between 3/16/25 through 3/28/25 did not identify any respiratory symptom screening, even though the facility had RSV cases. R11's record did not identify R28 had symptoms prior to 3/28/25. R11's progress note dated 3/28/25 at 1:32 p.m., identified R11 was not feeling well after 12:00 p.m., and appeared to be shaky, unable to transfer self, and needed supplemental oxygen, and 911 was called. Note at 2:16 p.m., identified R11 was transferred to hospital via ambulance.	21375		

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21375	Continued From page 25 R11's progress note dated 3/28/25 at 4:44 p.m., identified hospital called and R11 had tested positive for COVID and RSV. R11's hospital ED note dated 3/28/25, indicated R11 presented via EMS for evaluation of difficulty breathing, shaking, nausea, tachycardia, and low blood pressure. Heart rate in 140's with oxygen sats in the 70's and temperature of 100.4. R11's lung sounds were decreased with wheezing and rales present. R11 was transferred to higher level of care due to hypoxia secondary to new diagnosis of RSV and COVID. R11's progress notes dated 4/7/25, indicated R11 remained in ICU, was hallucinating, and was restless and needing supplemental oxygen at 4 liters per nasal cannula. R12 symptom onset 3/31/25, positive 3/31/25 R12's face sheet dated 4/10/25, indicated diagnoses of cancer of the prostrate, CHF and dementia. R12's record between 3/16/25 and 3/30/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 3/31/25. R12's progress notes dated 3/31/25, indicated R12 was showing decline in health, slightly diaphoretic (sweaty) and slightly elevated blood pressure. R12 was sent to ED for evaluation. R12's ED progress notes dated 3/31/25, indicated R12 was seen in ED following a fall and had mentation changes. R12 had a cough and nursing home staff reported increased lethargy. R12's assessment indicated a congested cough	21375		

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21375	Continued From page 26 with rhonchi (abnormal lung sounds caused by secretions or obstruction of airway) in left lower lobe. R12 tested positive for RSV in ED and was discharged back to the nursing home by private vehicle. R12's progress note dated 3/31/25 at 3:01 p.m., identified R12 returned to facility with a diagnosis of RSV. R12's record did not identify if and when TBP were implemented after return from ED. R12's progress notes from 3/31/25 through 4/8/25 lacked an ongoing symptom monitoring and utilization of TBP. During an observation on 4/1/25 at 5:07 p.m., R12 was noted in the hallway outside conference room without a mask on. Three staff walked by him. Nursing assistant (NA)-P stopped, applied gloves, and turned R12's wheelchair around, explained to R12 he needed to stay in his room as he was sick. NA-P was not wearing a mask and did not apply or offer one to R12 as he took him back to his room. During an observation on 4/3/25, at 5:12 p.m., approximately 15 residents were eating in the main dining room, 3-5 residents per table, without masks on. Resident were seated two to three feet apart. R12, who was RSV positive on 3/31/25, was seated a few feet from R15, neither one had mask on. Multiple staff were in the dining room, serving the meals and did not identify R12 should have been eating in his room. DON entered dining room and applied a mask to R12 and walked him out to his room from the main dining room. DON stated R12 should have been eating in his room and not in the main dining room. During an interview on 4/3/25 at 5:25 p.m., NA-H	21375		

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21375	Continued From page 27 stated R12 was supposed be eating in his room due to RSV, and if staff noticed him coming out of his room, staff walked him back to his room. During an interview on 4/4/25 at 10:58 a.m., ADON-IP stated she was not employed in the facility when the first case of RSV was detected and had not implemented contact tracing since she had started, however had started a map of the positive cases. ADON was not aware how many cases constituted an outbreak, but thought it was three or more. R12, R13, and R14 all ate meals together and she believed this was part of the spread and had just made that determination today on 4/4/25. If residents were exposed to another positive resident who had RSV they should have been kept in isolation, monitored closely for symptoms, and tested if symptoms develop. R17 symptom onset 4/4/25; positive for RSV on 4/9/25 R17's face sheet dated 4/10/25, indicated diagnoses of diabetes, paraplegia (paralysis of the legs and lower body), and diabetes. R17's record between 3/16/25 through 4/7/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/4/25. R17's progress note dated 4/4/25, R17 had reported he did not feel good but was not ill. R17's record did not include respiratory assessments until 4/8/25. R17's record did not identify a respiratory assessment/screener between 4/5/25 to 4/7/25. R17's progress note dated 4/8/25, indicated R17	21375		

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21375	Continued From page 28 had cough with congestion. However, the record indicated R17 was not tested for respiratory illness until 4/9/25. R17's laboratory report dated 4/9/25, indicated R17 tested positive for RSV. R6 symptom onset 4/6/25; positive for RSV on 4/9/25 R6's face sheet dated 4/10/25, indicated diagnoses of cerebrovascular accident (stroke), hemiplegia or hemiparesis (weakness on one side of the body). R6's record between 3/16/25 and 4/5/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/6/25. R6's progress note dated 4/6/25 at 8:45 p.m., R6 requested an RSV test as he was having a sore throat and raspy voice. R6's progress note dated 4/8/25, identified R6 was on quarantine due to unspecified outbreak. R6's progress notes dated 4/9/25, identified lab results received by facility and tested positive for RSV. R16 symptom onset 4/7/25; positive for RSV on 4/9/25 R16's face sheet date 4/10/25, indicated diagnoses of CHF, Parkinson's Disease (a progressive neurological disorder characterized by gradual loss of nerve cells in the brain, leading to tremors, slow movements, and rigidity), obstructive sleep apnea, myasthenia gravis an autoimmune disorder) and respiratory failure.	21375		

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21375	Continued From page 29 R16's record between 3/16/25 and 4/6/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/7/25. R16's progress note on 4/7/25 identified R16 had developed a cough with wheezing. R16 was placed on precautions and tested. R16's laboratory results dated 4/9/25, indicated R16 tested positive for RSV. R15 symptom onset 4/7/25 R15's face sheet dated 4/10/25, indicated diagnoses of chronic viral hepatitis C and sheltered homelessness. R15's record between 3/16/25 and 4/6/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/7/25. R15's progress note 4/7/25, identified R15 had developed sore throat. R15's laboratory report dated 4/9/25, indicated R15 tested negative for RSV, COVID and influenza. R7 symptom onset 4/8/25 R7's face sheet dated 4/10/25, indicated diagnoses of multiple sclerosis (MS- a chronic autoimmune disease that affects the brain and spinal cord). R7's record between 3/16/25 and 4/7/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/8/25.	21375		

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21375	Continued From page 30 R7's progress notes dated on 4/8/25, R7 had developed a sore throat, and hoarse voice. R7's laboratory results dated 4/9/25, indicated R7 tested negative for RSV, COVID and influenza. R18 symptom onset 4/8/25 R18's face sheet dated 4/10/25, indicated diagnoses of obstructive sleep apnea. R18 ' s record between 3/16/25 and 4/7/25 did not identify any respiratory symptom screening and did not have symptoms of illness prior to 4/8/25. R18's progress notes dated 4/8/25, R18 was noted to be coughing, stated it was his normal and respiratory assessment completed without any other symptoms noted. R18 was put on droplet/contact precautions, however refused to be tested for COVID, influenza and RSV. During an interview on 4/4/25 at 8:57 a.m., licensed practical nurse (LPN)-B stated monitoring for respiratory symptoms would include lung sounds, looking for symptoms like runny nose or cough. If new symptoms were found then the provider would be notified, the resident tested, and precautions put into place. LPN-B was not aware of any symptom monitoring being done for any residents at this time and this should be done. During an interview on 4/3/25 at 3:24 p.m., registered nurse (RN)-B stated if staff call in sick with respiratory symptoms, they would be asked to test for COVID, however, if negative then it must just be a cold, and could work while wearing a mask while working. If a resident became	21375		

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21375	Continued From page 31 symptomatic then staff would test and monitor symptoms, however, was not aware if the facility was doing that. RN-B stated she believed full facility masking and monitoring of all the residents for symptoms of RSV should have been initiated after the first case of RSV was in the facility. During an interview on 4/3/25 at 1:00 p.m., DON stated if there was a respiratory outbreak, the following would need to be initiated: staff masking, encourage resident masking, reduce the number of residents in activities, and limit numbers in dining room for meals. However, none of these activities had been done at this time, due to not identifying the cases of RSV as an outbreak. DON also stated not all the RSV cases had been added to a surveillance log to track the cases. DON stated a map of the cases in the facility had not been completed at this time to allow the facility track trend the infection. Staff illness was tracked, and no cases of respiratory illness had been identified. During an interview on 4/4/25 at 10:31 a.m., medical director (MD)-A stated was not aware of the facility's RSV outbreak until 4/3/25. His expectations during a respiratory outbreak would be for the facility to follow their policies on infection control/respiratory illnesses, notify the medical director, and follow recommendations from CDC/MDH on TBP. Any type of respiratory illness with a resident with other contributing factors, such as COPD, could lead to the likelihood of serious harm, impairment, or even death. The immediate jeopardy that began on 3/16/25, was removed on 4/8/25. when it was verified, the facility implemented the following: -Facility provided education to all staff pertaining	21375		

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21375	Continued From page 32 to PPE, implementation and removal of TBP, physician notification, active screening, and staff illness. -Facility updated the surveillance log -Facility implemented and developed a tracking log for staff illness. -Facility developed screening and monitoring tools for respiratory illnesses. -Facility developed and implemented a process for implementing and removing TBP's and physician notification. -Facility developed and implemented a process for testing residents. -Facility identified high risk exposures to RSV and placed those residents on isolation, -Facility implemented active screening on all residents to identify early symptoms and implemented TBP as applicable. -Implemented mask use for staff and visitors. -Facility provided education to all staff pertaining to PPE, implementation and removal of TBP, physician notification, active screening, and staff illness. -Facility updated the surveillance log -Facility implemented and developed a tracking log for staff illness. Review of facility's Infection Outbreak Response and Investigation Policy undated, identified an outbreak generally refers to the occurrence of more cases of a communicable disease than expected in a given area or among a specific group of people over a particular period of time. If a condition is rare or has serious health implications, an outbreak may involve only one case. Prompt recognition of an outbreak: The following triggers shall prompt an investigation as to whether an outbreak exist: -A sudden cluster of infections in a unit or during	21375		

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21375	Continued From page 33 a short period of time. -A single case of a rare or serious infection. Implementation of infection control measures: -symptomatic residents will be considered potentially infected, assessed for immediate need, and placed on empiric precautions while awaiting physician orders. -symptomatic employees will be screened by the Infection Preventionist/or designee. -In the event of a known communicable disease outbreak, the facility should screen visitors for signs and symptoms of the communicable disease in accordance with national standards. -Transmission based precautions will be implemented as indicated for the particular organism. -Surveillance activities will increase to daily for the duration of the outbreak. Outbreak investigation: -Last page was not provided Review of facilities undated and unsigned, Transmission Based (Isolation Precautions) Type and Duration of transmission-Based Precautions Recommended for Selected Infections and Conditions, chart dated 2024, indicated for RSV infection in immunocompromised adults, contact precautions was needed for duration of illness and to wear a mask according to standard precautions. Review of facility policy, dated 3/24/25, Infection Prevention and Control Program, indicated the following: 3. Surveillance: a. a system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteer, visitors, and other individuals providing services under a	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00939	A. BUILDING: _____ B. WING _____	C 04/09/2025

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21375	Continued From page 34 contractual arrangement based upon a facility assessment and accepted national standards. c. The registered and licensed practical nurses participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in house reporting of communicable diseases and infections. 13. Resident/Family/Visitor Education and Screening a. Residents, family members and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff. 19. Respiratory Illness Reporting: a. The facility must input the following information into the NHSN reporting module weekly: 3. confirmed resident cases of COVID 19, influenza, and RSV; 4. hospitalized residents with confirmed cases of COVID 19, influenza, and RSV (overall and by vaccination status). SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure appropriate screening, notification of signs and symptoms of illness, daily cumulative tracking and trending of all illnesses in the facility, immediate implementation of droplet precautions, and appropriate use of PPE are implemented to mitigate potential RSV transmission. The DON or designee could educate all staff on existing or revised policies and perform ongoing continuous audits to ensure compliance. Furthermore, the Director of Nursing (DON), ICP, or designee could review facility policy and	21375		

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21375	Continued From page 35 procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE to wear. They could also do environmental rounds and audits, and re-education anytime EBP are placed. The DON, ICP or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. Time Period for Correction: Twenty-one (21) days.	21375		