Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2023

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: CCN: 245349
Cycle Start Date: January 30, 2023

Dear Administrator:

On February 16, 2023, we notified you a remedy was imposed. On March 8, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 3, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 3, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of February 16, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 30, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
February 16, 2023

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: CCN: 245349
Cycle Start Date: January 30, 2023

Dear Administrator:

On January 30, 2023, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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 isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On January 27, 2023, the situation of immediate jeopardy to potential health and safety cited at F600 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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 3, 2023.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 3, 2023 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 3, 2023 (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.

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, Stewartville Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 30, 2023. 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, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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 July 30, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact 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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 16, 2023

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

Re: Event ID: TEBE11

Dear Administrator:

The above facility survey was completed on January 30, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: _____ B. WING _____	C 01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/19, 1/23 to 1/26 and 1/30/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H53497377C (MN00089993); however, no licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	C 01/30/2023

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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F 000	INITIAL COMMENTS On 1/19, 1/23 to 1/26 and 1/30/23, 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 an immediate jeopardy (IJ) to resident health and safety at F600. The IJ began on 1/18/23, when the facility failed to ensure residents were free from neglect when they allowed two nursing assistants who were suspected of chemical impairment to work in the facility. The administrator and the director of nursing (DON) were notified of the IJ on 1/25/23, at 5:28 p.m. The IJ was removed on 1/27/23, at 5:30 p.m. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 1/30/23. The following complaint was found to be SUBSTANTIATED: H53497377C (MN00089993) 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 substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/24/2023

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 regulations has been attained in accordance with your verification.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from neglect when they allowed two nursing assistants (NA)-A, NA-B, who were suspected of chemical impairment to work in the facility. NA-A and NA-B both tested positive for illicit drugs. 3 of 3 residents (R2, R3, R4) sustained falls that resulted in injuries when NA-A and NA-B did not follow the care plan. This resulted in an immediate jeopardy (IJ) for resident health and safety when NA-A and NA-B provided care. The IJ began on 1/18/23, when the facility failed to ensure residents were free from neglect when they allowed two nursing assistants who tested positive of chemical impairment to work in the	F 600	Stewartville Care Center policy reflects the residents right to be free from abuse, neglect, misappropriation of property, and financial exploitation. To the best ability possible the facility implements measures to ensure the safety and well-being of each resident and ensures that all staff are trained and knowledgeable in how to reduce the risk of abuse and neglect. The goal is to provide a safe resident environment and protect residents from abuse and neglect. Following facility policy, the staff are instructed to immediately intervene as necessary to ensure the safety of	2/24/23

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F 600	Continued From page 2 facility. The administrator and the director of nursing (DON) were notified of the IJ on 1/25/23, at 5:28 p.m. The IJ was removed on 1/27/23, at 5:30 p.m. but scope and severity remained at a level D, no actual harm with potential for more than minimal harm. Findings include: NA-A's employee file dated 1/31/22, included a self-reported history of alcoholism. On 2/1/22, the facility implemented a plan to breathalyzer NA-A at beginning and middle of her shift while employed. On 2/20/22, NA-A reported to work at 6:30 a.m. and had a breathalyzer test (A breath alcohol test determines how much alcohol is in your blood) of 0.13 (0.08 is considered legally intoxicated in the state on Minnesota.) NA-A was sent home before starting her shift. The facility did not complete any breathalyzer testing after 5/10/22. NA-A's employee file contained NA-A's Escreen (an online portal that enables individuals to schedule and pay for drug screening and testing services and receive the online results.) Specimen Result Certificate dated 1/18/23, at 9:31 a.m., showed positive presence of amphetamines (a synthetic, addictive, mood-altering drug, used illegally as a stimulant). The report indicated the laboratory confirmation cutoff for a positive test of amphetamines as being 500 (nanograms/milliliter) ng/ml and this specimen indicated NA-A's result of over 1000 ng/ml. The result disposition of this specimen indicated NA-A's specimen as being positive for amphetamines. NA-B's employee file contained NA-B's Escreen	F 600	residents. The interdisciplinary team investigates incidences with the goal to understand causal factors and protect residents from abuse/neglect. Interventions are implemented and resident care plans are revised as indicated. Incidents of alleged abuse and neglect are reported to the appropriate regulatory agency. The facility's Vulnerable Adult Abuse policies and procedures were reviewed and found appropriate. The goal and commitment are to adhere to all laws, regulations and policies including prohibiting impaired persons from creating an unsafe resident care environment and to provide employees with the information and support they need facilitate resident safety. The facility has purchased a rapid detection over-the-counter drug screening tool to use if impairment is suspected. A new employee policy entitled, The Three I's Policy Intoxication, Impairment & Under the Influence, was drafted to specifically address impaired-related risks in the workplace. The policy includes 1) the process for rapid testing and removal of a person suspected of impairment 2) appropriate action to take following completion of the rapid testing 3) steps for completion of an investigation to determine any possible impacts on residents by an impaired staff member and 4) instructions to staff who feels a person is creating a safety risk but is not comfortable asking them to leave or when	

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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F 600	Continued From page 3 Specimen Results Certificate dated 4/11/22, at 8:36 a.m. Employee file identified on her pre-employment drug screen sent to Escreen on 4/5/22, at 2:00 p.m. showed a positive presence of marijuana. The report indicated the laboratory confirmation cutoff for a positive test of marijuana as being 15ng/ml and this specimen indicated NA-B's result of over 50ng/ml. The result disposition of this specimen indicated NA-B's specimen as being positive for marijuana. On 1/19/23, at 1:09 p.m. an interview was conducted with NA-C. NA-C stated she had reported concerns to registered nurse (RN)-A about NA-A smelling of alcohol and sneaking out the window to drink in NA-A's truck during a shift. NA-C also stated on a shift in November (unknown date), NA-A had ran into a parked car in the parking lot and come into work smelling of alcohol. NA-C stated she did not feel NA-A was safe to continue to work at the facility as residents continued to fall on NA-A's shifts. NA-C stated she felt management was aware of her concerns because NA-C had told management she refused to work at the same time as NA-A, because N-A came to work impaired, and NA-C didn't want to work with someone you could not rely on. On 1/19/23, at 1:48 p.m. an interview was conducted with RN-A. RN-A stated she was aware that both NA-A and NA-B were supposed to be in recovery. RN-A stated she had heard about NA-A and NA-B coming to work chemically impaired in the past, and had heard about NA-A drinking at work last week. RN-A stated she had gotten calls from staff with concerns of NA-A and NA-B being at work impaired, and she told the staff to send them home. RN-A stated the last time she had told someone to send one of them	F 600	asked to leave they refuse. The staff were instructed on the new policy and reinstructed on being a mandated reporter. The staff completed a post-test and signed to verify receipt and understanding of the related policy and regulatory information. To further ensure the continued safety of the residents, the Director of Nursing conversed with and observed each staff member present in the facility on 01/26/2023 to verify that no staff members present were exhibiting any signs of impairment. The staff were observed for suspicious odors, slurred speech, dilated pupils, unusual gait or balance or any other behavior that seemed outside of what would be considered normal human behavior. All staff present in the facility were found to be fit for duty. All staff were re-educated on being a mandated reporter, the procedures for reporting resident care concerns, and steps the staff should take if they have reported using the chain-of-command and feel there was inadequate follow up to their concerns. A post-test verified understanding of the information. All new employees are informed of their responsibility as mandated reporters and of the residents' right to be free from abuse, neglect, mistreatment, and financial exploitation. Instruction also includes identifying and reporting impaired persons who may pose a risk to the resident. Each staff member has been	

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F 600	Continued From page 4 home was a few months ago. RN-A stated she has had to do some coaching and re-education with NA-A when she had completed a transfer wrong and nearly dropped a resident when she wasn't using a gait belt during the transfer. RN-A stated she was unable to recall date of the coachings but stated it had been more than once On 1/19/23, at 2:23 p.m. an interview was conducted with director of nursing (DON) who stated she had heard allegations of NA-A drinking on the facility premises and sneaking out the window to avoid facility camaras on the weekend of the January 1st, 2023. The DON did not come to the facility but reviewed the camera footage on January 2nd, 2023, and stated she had not found anything concerning. The DON stated NA-A and NA-B did not have any substance abuse concerns in their employee files (despite NA-A self-reporting concerns and being breathalyzed previously at the facility). The DON stated she had NA-A and NA-B drug tested on January 3rd, 2023, to rule out staff suspicions of intoxication at work. The DON stated NA-A had never tested positive for alcohol at work during her breathalyzer testing contract. The DON stated NA-A's drug screen from 1/3/23, had come back positive for amphetamines (a synthetic, addictive, mood-altering drug, used illegally as a stimulant and legally as a prescription drug to treat children with ADD and adults with narcolepsy) on 1/18/23. NA-A had admitted to taking Vyvanse (a stimulant medication that is mainly used to treat attention deficit hyperactivity disorder in people over the age of five.) and continued to stay on the schedule and work pending the DON getting direction from the Escreen doctor on how to proceed on 1/23/23 when the doctor would be available for consultation. The DON stated she	F 600	issued a small laminated reference card to attach to their name tag lanyard which lists the signs and symptoms of drug impairment and the chain of command for reporting suspicions of drug impairment. The Director of Nursing reviewed information and documentation from January 3, 2023 to January 19, 2023 and found two incidences related to care provided by assistants NA-A and NA-B. There were no negative resident outcomes. However, to ensure a continuing safe resident care environment, the employment of NA-A and NA-B was officially terminated. On January 26, 2023, a report was submitted to the Board of Nursing informing the Board of the actions of NA-A who holds a license regulated by the Board. The licensed staff will receive education on the roles and responsibilities of licensed nurses as outlined in the Nurse Practice Act including the practice of "providing safe and effective nursing care; promoting a safe and therapeutic environment; and advocating for the best interests of individual patients . . ." The nurses will sign acknowledging receipt and understanding of the Nurse Practice Act information. The staff have been reeducated on safe resident transfers. The Director of Nursing/designee will continue to routinely review resident incidents to ensure the mobility/transfer plan of care is being followed. A more comprehensive review of	

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F 600	Continued From page 5 was not concerned about diversion related to the positive amphetamine test with NA-A, because no current residents had orders for amphetamines. The DON stated the facility was aware that NA-B had a prescription for medical marijuana and the DON had no concerns for NA-B's work performance with residents. The DON stated they had no monitoring of NA-A and NA-B's work performance related to their known chemical abuse history. On 1/19/23, at 5:13 p.m. an interview was conducted with the administrator who stated the DON had informed him on the day of the survey 1/19/23, she had a copy of NA-B's medical marijuana card in NA-B's employment file. The administrator stated he had reviewed NA-B's employment file and was unable to locate a medical marijuana card and had found a pre-employment drug test that was positive for marijuana. The administrator was unsure if staff would be able to work when using medical marijuana and would have to review the facility policy. The administrator stated nothing had been or was currently in place for monitoring impairment in NA-A or NA-B. The administrator stated he had thought both NA-A and NA-B had been removed from the schedule on 1/3/2023 pending further investigation, he was unaware NA-A and NA-B continued to be on the schedule. On 1/23/23 at 9:04 a.m. an interview was conducted with assistant director of nursing (ADON). The ADON stated he had been the person who tested NA-A with the portable breathalyzer on 2/10/22, and had sent her home. The ADON stated he was instructed by the DON to breathalyze NA-A at the beginning of her shifts back in February of 2022, but he was not sure	F 600	the circumstances surrounding a fall will be completed when the post-fall investigation indicates the plan of care may not have been followed. Resident number 1 - The resident was receiving hospice services and died peacefully at the facility September 22, 2022. The circumstances of the May 8, 2022 fall have been reviewed as part of the facility's ongoing quality improvement process. Resident number 2 - The resident's care plan addressing falls was reviewed and updated. The documentation and staff response related to the two most recent falls were reviewed. The staff was following the plan of care at the time of the incidents. Resident number 3 - The resident's care plan addressing falls was reviewed and updated. The documentation and staff response related to the December 28, 2022 fall were reviewed as part of the facility's performance improvement process. The resident has had no further falls. Resident number 4 - The resident's care plan addressing falls was reviewed and updated. The documentation and staff response related to the December 27, 2022 fall were reviewed as part of the facility's performance improvement process. The resident has had no further falls.	

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F 600	Continued From page 6 who was supposed to breathalyzer her in the middle of her shifts. The ADON stated he had called the DON and informed her he had sent NA-A home on 2/10/22, related to the positive breathalyzer test. The ADON stated the DON informed him he had done the right thing, and she would have to meet with NA-A and have a conversation with her before NA-A's next work shift. The ADON stated staff had reported concerns of NA-A and NA-B coming to their shifts smelling of drugs and alcohol, but he had not observed this himself. The ADON stated he had usually been informed of the concerns a day or more after these occurred, so he was unable to determine the accuracy of these allegations. On 1/23/23, at 1:30 p.m. an interview was conducted with NA-D. NA-D stated she had worked with both NA-A and NA-B, and had reported her concerns to nurses on the floor as well, as the DON and administrator. NA-D stated she had reported seeing NA-A drinking in her truck at work, and being intoxicated, to her charge nurse. NA-D stated she was told by licensed practical nurse (LPN)-B, "Yeah, she (NA-A) probably is." NA-D stated she personally witnessed NA-B transferring patients without her gait belt, and the residents falling and getting injured. NA-B stated she was present during at least five residents falls related to NA-B. NA-D stated she asked NA-B if she was impaired at work during one of her shifts, and NA-B had admitted she was. NA-D stated she observed NA-B transferring a resident with no gait belt, and the resident fell and hit her head on the floor causing a large "goose egg" on the resident's (R6) forehead. NA-D stated, "Four of the residents are no longer with us. (R6) passed away last Tuesday, and I feel real bad." NA-D	F 600	Resident number 6 - The resident died at the facility January 18, 2023. The circumstances of the January 5, 2023 incident have been reviewed as part of the facility's ongoing quality improvement process. The survey findings stated "on 1/23/2023 interview with NA-D stated she witnessed NA-B 'drop R6 causing R6 to hit her head on the ground'". An investigation of the 1/5/2023 incident found that the fall was unwitnessed. The resident called for help and was found on the floor next to her bed by the staff. R6 reported she hit her head; no injuries were noted. Compliance with safe resident transfers will be monitored weekly for three months by the Director of Nursing/designee through direct observation and record audit to ensure residents are being transferred according to their plan of care with a focus on correct use of supportive/safety equipment. The care plans of residents who have had falls in the past 45 days will be reviewed by February 24, 2023 to ensure the safety risks are identified and appropriate interventions are in place to reduce the risk of falls. The fall risk care plans of all residents will be continue to be reviewed during their quarterly care conference. The Social Worker will be responsible for monitoring the appropriate and timely response to reports of suspicions of impaired care givers. The Social Worker's findings will be reviewed with the Administrator to ensure compliance with	

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F 600	Continued From page 7 stated she witnessed NA-B transferring another resident without her gait belt, and NA-B let go of the resident and she fell, and NA-B put the gait belt on after the fall. NA-D stated she reported the incident to the floor nurse (LPN-A.) NA-D stated she had witnessed NA-A and NA-B always on break, and she could see them smoking out on the corner of the building. NA-D stated NA-B smoked "her pen thing that smelled of marijuana, out on the corner for hours." NA-D stated NA-B had sat in NA-D's car at work one day and she witnessed NA-B rolling a white substance in white paper in NA-D's car and smoking it. NA-D stated she became upset, and had another co-worker assist her to get NA-B out of NA-D's car. NA-D stated she was so upset she went to the DON and threatened to quit after the incident, and the DON stated she couldn't do anything because the DON wasn't present when the incident happened. NA-D stated she asked NA-B directly if she used chemicals at work and NA-B told NA-D she used alcohol, and meth only on her breaks and at home. NA-D stated she had gone to the administrator with her concerns, and he stated, "he would look into it" but he never got back to her. NA-D stated she felt her concerns were not being addressed. On 1/24/23, at 11:11 a.m. an interview was conducted with trained medication assistant (TMA)-A. TMA-A stated she had been told by NA-D of concerns of NA-A drinking at work the previous week. TMA-A stated NA-D had told the nurse on duty about NA-A appearing drunk and was told, "She probably is." TMA-A stated NA-A and her schedules did not overlap because NA-A came to work late most shifts. TMA-A stated management had to be aware of NA-B's substance addictions, because NA-B talked	F 600	related facility policies. If noncompliance is noted with the resident's mobility plan of care or with response to reports of impaired care givers, additional monitoring and education will be done. Compliance will be reviewed during the quarterly March Quality Assurance and Quality Improvement Committee meeting and ongoing.	

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F 600	Continued From page 8 openly about it, and the DON had to work around NA-B's treatment schedule. TMA-A reported she was aware of NA-B having frequent falls with the residents related to NA-B not using her gait belt. TMA-A stated she witnessed NA-B with R2 on the floor and putting on the gait belt after the fall. TMA-A stated R2 ended up going to the hospital and having hip problems. TMA-A stated NA-B had multiple falls with residents and had been reported under the influence to management. On 1/24/23, at 12:11 p.m., an interview was conducted with DON stated she was aware of NA-B completing her treatment. The DON stated she had never asked NA-B if she had ever used chemical substances at work or come to work impaired. The DON stated she had not received results of NA-B's Escreen. The DON stated she had not put any monitoring in place for NA-B, and was aware of NA-B had chemical dependency issues. The DON reported after being asked to call the lab for results, NA-B had texted the DON's phone and informed the DON that her Escreen was positive for cocaine and marijuana. On 1/24/23, at 2:21 p.m. an interview was conducted with LPN-A. LPN-A stated she had been present during falls with NA-A and NA-B, and had to provide education on using gait belts and transferring residents properly. LPN-A also reported an incident when a resident had fallen and had sustained a hip injury. LPN-A stated she had specifically asked NA-A and NA-B to not walk the resident, only to return later in the shift and find NA-A and NA-B were walking the same resident she had specifically asked them not to walk. LPN-A stated NA-A's appearance at work has been questionable at times, with her coming to work with red, blood shot eyes and a	F 600		

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F 600	Continued From page 9	F 600		

disheveled appearance. LPN-A stated NA-A and NA-B were known to take numerous breaks. LPN-A stated she was present when RN-A had told NA-A and NA-B they couldn't take a break yet as they had just gotten to work. LPN-A stated she could remember this had happened with in the last month but was unable to determine exact date.

On 1/24/23, at 2:55 p.m. an interview was conducted with NA-E who stated she had heard of people jumping out the windows at the facility to avoid being seen by the facilities cameras. NA-E reported NA-A was aware of her breaks being tracked by the DON. NA-E stated NA-A was going out the window to make it harder for the DON to track her breaks. NA-E stated when she worked with NA-A and or NA-B, she frequently would not get her breaks because the two would be on break so much, and things needed to get done so she wouldn't take her breaks.

On 1/24/23, at 4:12 p.m. an interview was conducted with RN-C who stated she had a shift that occurred in December 2022, when NA-C had come to her with concerns related to NA-A acting odd and drinking alcohol. NA-A had told RN-C she had reported her concerns to RN-D, and nothing had been done. RN-C stated she had RN-D handle the situation before the end of RN-D's shift. RN-C stated NA-A had been tested with the breathalyzer and it had been zeros indicating no alcohol, and NA-A was still sent home because she was upset and seemed out of sorts. RN-C stated one other time, two NA's had been working with NA-A, and observed her in her truck drinking and charting while she was on the clock. RN-C stated she had not been at the

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F 600	Continued From page 10 facility when she received the phone call and the NA's were reporting the incident had happened at work on the previous day. RN-C stated she had directed the reporting NA to write up a statement, make a copy of it, and put it under the DON's door as proof of the report. RN-C stated she herself had texted the DON on the day she received the report from the NA's. RN-C stated she may have even shoved the papers under the DON's office door herself on the Monday after the incident happened, but was not positive if she did or not. RN-C stated she later reported the text on her phone to the DON was on September 5th, 2022. On 1/25/23, at 12:14 p.m. an interview was conducted with drug testing company certified medical reviewer (CMR, who was a medical doctor). CMR reported the testing completed for NA-A and NA-B were regulated tests, and there were very strict procedures that were followed for these tests to ensure accuracy. CMR reported that NA-A's test was a confirmatory positive test for amphetamines, and that 500 was considered confirmatory, and NA-A's test was 1900. CMR stated he would consider this a positive test with no legitimate explanation for the result of four times the confirmatory sample. CMR stated he would consider her impaired if she was to work at this level of intoxication. CMR reported NA-B had informed the tester she had a medical marijuana card, but was unable to produce it for the test, and declined to provide a prescription list or medical diagnoses for the test. MD-A stated NA-B's test for cocaine was twice the cut off, and she had tested positive for marijuana with 400 being the mean of what is considered a high-test, NA-B's test was at 1373. The CMR stated he felt both would be considered impaired and not safe	F 600		

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F 600	Continued From page 11 to work with the vulnerable population on the day they were tested. On 1/25/23, at 2:57 p.m. an interview was conducted with NA-F who stated she had smelled alcohol on NA-A and reported it to RN-C after the Labor Day weekend. NA-F stated she had gone to the DON's office after that weekend and told the DON she was quitting because she was tired of dealing with NA's being impaired at work. NA-F reported that she had reported her concerns to RN-C, they had written out the letter together, and she then had gone into to the DON's office to talk to her face to face. NA-F stated she told the DON she was not going to do it anymore, that NA-A and NA-B were always outside, and work was not being done because you couldn't find them. NA-F stated nothing had changed, and the DON never got back to her after her report. On 1/25/23, at 4:19 p.m. an interview was conducted with the administrator. the administrator stated he was not aware of a history of impairment with NA-A or NA-B. The administrator stated he was not aware of the breathalyzer contract between NA-A and the DON in February of 2022. Administrator stated he did receive one call at home from RN-D one evening, and was told by RN-D the DON told her to inform him of NA-A being sent home, but her breathalyzer test had been negative. The administrator stated when it came to staff coming to work impaired or suspicion of being impaired, he would follow the facility policy. The administrator stated he would depend on his nurses to determine if a staff could work or not. The administrator stated, "I did not know (NA-A) or (NA-B) worked on the day of the testing on Jan 3rd, and was not aware they had returned to work	F 600		

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F 600	Continued From page 12 before we had received the test results." The administrator stated he would increased monitoring if there were concerns of staff using chemicals. A review of resident's incident reports indicated: -R1's fall event report dated 5/8/22, at 12:47 p.m. indicated NA-A transferred resident with one person transfer having R1 stand and ambulate to transfer causing a fall. R1's care plan dated 9/30/2021 identified R1 required a full body lift and two staff for transfers. -R2's Fall Scene Investigation Report (FSI) dated 11/18/22, at 8:00 a.m., indicated R2 fell in the bathroom during a transfer with NA-B. 5 whys completed by LPN-A indicated, "Gait belt not in use." Interventions included gait belt or consider stand for all transfers. -R2's progress note dated 11/18/22, at 1:13 p.m., identified R2 had a fall earlier and had landed on her left hip. R2 reported hip was painful. physician assistant ordered R2 sent to emergency department for evaluation of left hip. -R2's progress note dated 11/18/22, at 11:29 p.m., stated R2 admitted to the hospital for "bleeding into the hip." -R3 Progress note dated 12/28/22, at 4:22 p.m., stated R3 let go of white stand and had a fall while being toileted resulted in large bruising to her hand, small skin tear on right mid forearm.-R3's Care Plan approach dated 11/3/22, stated R3 was to have two staff assist her to transfer to and from chair and bed using sit to stand lift. Assess residents strength when using white stand and be aware she becomes weak, not able to maintain grip. -R3 progress note dated 12/28/22, at 7:03 p.m. stated new bruises and skin tear.	F 600		

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F 600	Continued From page 13 -In an email received from DON dated 1/25/23, at 1:32 p.m., stated the facility had not created a fall event for R3's fall on 12/28/22, so no investigation had been completed. DON indicated NA-A had been assigned to the hall of R3 on the date and time of the fall. -R4 FSI dated 12/26/22 at 6:50 p.m., indicated R4 was rushing in bathroom with NA-B when resident lost balance and fell. FSI indicated NA-B had not used a gait belt during the transfer. Recommendations on the FSI stated,"Do not rush, use transfer belt, gripper socks and use assistive device if resident appears weak." -R6 fall on 1/7/23 states resident had a fall from a wheelchair hit her head causing large goose egg. -On 1/23/23, 1:30 p.m. interview with NA-D stated she witnessed NA-B, "drop R6 causing R6 to hit her head on the ground." NA-D stated NA-B doesn't follow resident care plans. NA-D stated she has observed NA-B put gait belts on after the falls. The facility policy The 3 I's Policy Intoxication, Impairment & Under the Influence dated 1/27/23, directed the facility is committed to health and safety of the facility and will work together to control impairment-related risks in the workplace. The facility's Vulnerable Adult Policy dated 11/17/20, directed each resident has a right to be free from abuse and defined abuse including "Neglect" as the failure of the facility, its employees or service provider to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. The immediate jeopardy that began on 1/25/23, at 5:28 p.m. was removed on 1/27/23, at 5:30	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	C 01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 14 p.m. when it was verified through interview and document review the facility implemented the following: -immediately reviewed/revised policy/procedures for protecting residents from impaired staff. Including investigation on any impact of impairment to residents. -Identified and determined if any staff members were impaired and didn't allow them to work with residents. -Educated all staff on signs and symptoms of alcohol and illicit drug intoxication, and protocols for reporting to administration. -Educated the DON how to respond to concerns brought forward by staff, monitoring and supervision of staff with known chemical dependency issues, education on protecting residents when reasonable suspicion of impairment is determined and/or staff are drug tested. .	F 600		