Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 7, 2023

Revised Letter

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

RE: CCN: 245360
Cycle Start Date: August 23, 2023

Dear Administrator:

This letter sent on November 7, 2023, will replace the letter dated November 6, 2023. The effective date for the loss of NATCEP should be September 21, 2023.

On October 6, 2023, we notified you a remedy was imposed. On October 4, 2023, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 19, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 21, 2023 did not go into effect. (42 CFR 488.417 (b))

As we notified you in our letter of October 6, 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 September 21, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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November 7, 2023

Revised Letter

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

Re: Reinspection Results
Event ID: Y6YB12

Dear Administrator:

This letter sent on November 7, 2023, will replace the letter created on November 6, 2023, to correct the survey completed date.

On October 26, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 21, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
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October 6, 2023

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

RE: CCN: 245360
Cycle Start Date: August 23, 2023

Dear Administrator:

On September 11, 2023, we informed you that we may impose enforcement remedies.

On September 21, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. 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. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On September 15, 2023, 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.

Also, on September 21, 2023, the situation of immediate jeopardy to potential health and safety cited at F760 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 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 October 21, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective October 21, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 21, 2023.

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

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

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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, Glenoaks Senior Living Campus is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 21, 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 ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance

has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 23, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

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.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 9/11/23 through 9/15/23 and 9/18/23 through 9/21/23, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The IJ began on 7/30/23 at 8:22 a.m., when a Hoyer lift being used to transfer R2 would "not stop" and a different Hoyer lift had to be used to complete the transfer. The Hoyer lift was placed out of service for a short period but returned to service before the facility completed an internal investigation or contacted the manufacturer for direction. Additionally, the facility failed to have a system for routine maintenance related to a ceiling lift used to transfer R1 which had ongoing staff reports of malfunction over the last six months and failed to reassess R1's safe transfer in a Hoyer lift, both potentially causing R1 discomfort and pain. The DON and administrator were notified of the IJ on 9/14/23, at 5:35 p.m. The IJ was removed on 9/15/23, at 5:35 p.m. but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy. In addition, a second IJ was cited: The immediate jeopardy began on 8/28/23, when the facility failed to perform a physician ordered INR (international normalized ratio - blood clotting rate) blood test leading to a lack of subsequently provided anticoagulant medication order(s). As a result, R4 was not administered anticoagulation	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/16/2023

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 medication(s) from 8/28/23 through 9/10/23. In addition, after the anticoagulation clinic updated the facility related to R4's 8/28/23 missed INR and resultant anticoagulant medication, R4 missed two additional doses on 9/15/23 and 9/17/23, and received one dose higher then ordered on 9/16/23. This resulted in immediate risk of serious harm for R4. The facility administrator, the clinical nurse consultant (NC)-A, and licensed practical nurse (LPN)-E, were notified of the immediate jeopardy at 2:26 p.m. on 9/20/23. The immediate jeopardy was removed on 9/21/23 after the facility implemented a removal plan; however, non-compliance remained at the lower scope and severity level 2 D scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted substandard quality of care, and an extended survey was conducted from 9/18/23 through 9/20/23. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 9/18/23 through 9/20/23. The following complaints were reviewed: H53605825C (MN96846); H53605542C (MN96858) with deficiency cited at F760; H53605624C (MN96859) with deficiency cited at F760; H53605543C (MN96857) with deficiency cited at F760; H53605435C (MN96798) with deficiencies cited at F725 and F677; H53605348C (MN96634); H53605148C (MN96483) with deficiency cited at F725 and (MN96527 and MN96478) with	F 000		

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F 000	Continued From page 2 deficiency cited at F684. As a result of the investigation, deficiencies were also cited at F585, F609, F610, F689, F727, F744, F755, F865, and F921. 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 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		10/16/23

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F 585	Continued From page 3 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as	F 585		

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F 585	Continued From page 4 necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to take immediate action to prevent further potential violations, immediately report	F 585	The plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth	

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F 585	Continued From page 5 alleged violations, ensure written grievance documentation decisions to included; dates, grievance summary, investigation summary, statements, findings, action taken, conclusion, and communication by facility for 1 of 1 resident (R7) who was alleged to have not received staff care for an extended period of time and filed a grievance with facility. Findings include: R7's quarterly MDS dated 7/27/23, indicated R7 was severely cognitively impaired had Alzheimer's disease, dementia, anxiety, and depression. R7's Care Plan dated 8/23/23, indicated R7 requires assist of two with activities of daily living, requires two person assist with toileting and peri-care with every incontinent episode as necessary. During interview on 9/12/23 at 8:12 p.m., family member (FM)-F stated she had a camera put in R7's room two to three months ago due to noticing bed wetting and had concerns she was not getting changed after incontinent episodes of bowel and bladder. FM-F stated she had filled out a grievance forms and gave them to the director of nursing (DON) and the administrator and received no follow up on any of them. FM-F stated the only thing she noticed was a sign placed in R7's room to check and change every two hours and lay down after meals. Review of facility Resident Grievance Form's on R7 indicated the following: -On 8/18/23 Resident Grievance Form filled out by FM-F indicated, R7 was changed on 8/17/23 at	F 585	of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with state and federal law. F585-Grievances Glen Oaks has an established a grievance policy to ensure the prompt resolution of all grievances regarding the resident□s rights. 1. R7 was affected by the grievance process not being implemented correctly. The facility has conducted a care conference with the family members of R7 to ensure that all grievances have been addressed. 2. All residents have the potential to be affected. 3. All staff have been educated on the grievance process 10/12/23. 4. The grievance process was also reviewed with resident council. 5. The grievance binder will be brought to the morning quality conference to discuss with the IDT any grievances that have been filed. 6. The administrator will perform a monthly audit of the grievance log as required by the QAPI program. 7. The IDT to review grievances on an ongoing basis with results forwarded to the QAA committee for further review. Responsible party: NHA/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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F 585	Continued From page 6 8:00 p.m. to 8:30 p.m. and not again until 8/17/23 in the morning she was not touched or changed for nine hours. The grievance form further indicated FM-F stated this was very concerning because she could have fell or passed away and no one checked on her all night until 5:34 a.m. The form indicated under investigation/outcome completed by the DON. Educated staff on respect, dignity, job performance expectations. Discussed checking and changing every two hours. Also placed signs in memory care unit. The form also indicated FM-A was notified of the outcome and was satisfied with the resolution. the DON signed the form along with the administrator. During follow up interview on 9/12/23 at 8:30 p.m. FM-F stated there was an additional Grievance Form she filed on 8/18/23, which was informing the DON and the administrator R7 was not checked or changed on 8/18/23 from from 7:30 a.m. until 6:30 p.m. FM-A stated she went 11 hours without being checked or changed when camera was reviewed. FM-A further stated she was also informed by the evening staff when she was changed after supper and cheerios from breakfast were found in her incontinent brief. FM-A stated no one ever followed up with her on either grievance related to care concerns. FM-A also confirmed the facility never requested to review the footage as a part of an investigation or response to her concerns. During interview with the administrator on 9/18/23 at 1:00 p.m., stated he was not aware of the incident that occurred with the cheerios but was aware there was a camera in R7's room. The administrator then stated FM-A was always in the DON's office and was surprised there was never	F 585		

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	245360	A. BUILDING _____ B. WING _____	C 09/21/2023

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F 585	Continued From page 7 any resolution. The administrator stated the DON would not be in the facility for the rest of the week with a family emergency. The administrator stated he was unable to find the second grievance form. During interview on 9/20/23 at 6:30 p.m., with facility nurse consultant (FNC) stated a follow up and resolution should have been completed with the grievances. The FNC also stated an investigation should have been completed and looked into to see if abuse or neglect had occurred with each incident and then reported if needed. The Grievance Forms lacked evidence an investigation was completed by the facility, statements were taken, videos were requested or reviewed, staff were interviewed, alleged neglect violation were reported to State Agency, or communication with family over grievances were completed (per interview). The facilities Grievance/Concern Reporting, Investigation and Resolving policy updated 1/11/22 indicated, all residents/resident representatives and visitors have the right to voice grievances and/or concerns without fear or retaliation. The policy further indicated a complete investigation of the grievance should be conducted and documented on the grievance form and follow-up should be conducted with the resident and/or representative to determine that an acceptable resolution is established. All grievances should be handled in a timely fashion, with typical resolution be sought within 5-7 business days.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		10/16/23

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F 609	Continued From page 8 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of neglect was reported immediately, within two hours, to the State Agency (SA) for 1 of 1 resident (R7) who was alleged to have not received staff care for an extended period of time. Findings include:	F 609	F609 reporting of alleged violations The facility does ensure allegations of neglect are reported immediately within two hours to the state agency. 1. All residents have the potential to be affected. 2. All Staff, including facility leadership	

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F 609	Continued From page 9 R7's quarterly MDS dated 7/27/23, indicated R7 was severely cognitively impaired had Alzheimer's disease, dementia, anxiety, and depression. R7's Care Plan dated 8/23/23, indicated R7 requires assist of two with activities of daily living, requires two person assist with toileting and peri-care with every incontinent episode as necessary. Review of facility Resident Grievance Form's on R7 indicated the following: -On 8/18/23 Resident Grievance Form filled out by FM-F indicated, R7 was changed on 8/17/23 at 8:00 p.m. to 8:30 p.m. and not again until 8/17/23 in the morning she was not touched or changed for nine hours. The grievance form further indicated FM-F stated this was very concerning because she could have fell or passed away and no one checked on her all night until 5:34 a.m. The form indicated under investigation/outcome completed by the DON. Educated staff on respect, dignity, job performance expectations. Discussed checking and changing every two hours. Also placed signs in memory care unit. The form also indicated FM-A was notified of the outcome and was satisfied with the resolution. the DON signed the form along with the administrator. During interview on 9/12/23 at 8:30 p.m. FM-F stated there was an additional Grievance Form she filed on 8/18/23, which was informing the DON and the administrator R7 was not checked or changed on 8/18/23 from from 7:30 a.m. until 6:30 p.m. FM-A stated she went 11 hours without being checked or changed when camera was	F 609	were re-educated on the abuse and neglect policy/procedures and proper investigations for all types of abuse including neglect. The facility will continue to follow abuse allegation protocols to ensure the protection and safety of all residents 10/12/23. 3. A Care conference was conducted with family members of R7 to ensure any grievances were addressed, and any allegations of neglect were identified to prevent the deficient practice from reoccurring. 4. Facility grievance program will be utilized to identify any potential allegations of abuse or neglect. 5. The Admin/Designee will audit abuse allegations to ensure policy and procedures are followed and protection of all residents with results forwarded to the QAA Committee for review. Audit weekly X 4, monthly X 6 Responsible Party: ADM/Designee	

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F 609	Continued From page 10 reviewed. FM-A further stated she was also informed by the evening staff when she was changed after supper and cheerios from breakfast were found in her incontinent brief. FM-A stated no one ever followed up with her on either grievance related to care concerns. During interview with the administrator on 9/18/23 at 1:00 p.m., stated he was not aware of the incident that occurred with the cheerios but was aware there was a camera in R7's room. The administrator then stated FM-A was always in the DON's office and was surprised there was never any resolution. The administrator stated the DON would not be in the facility for the rest of the week with a family emergency. The administrator stated he was unable to find the second grievance form. During interview on 9/20/23 at 6:30 p.m., with facility nurse consultant (FNC) stated a follow up and resolution should have been completed with the grievances. The FNC also stated an investigation should have been completed and looked into to see if abuse or neglect had occurred with each incident and then reported if needed. A Nursing Facility Abuse, Prevention, Identification, Investigation and Reporting Policy updated 2/06/23, indicated neglect of a dependent adult "means deprivation of the minimum of food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependents adult's life or physical or mental health. The policy further indicated neglect is the failure of the facility, its employees or services providers to provide goods and services to a resident that as necessary to avoid physical harm, mental anguish, or mental	F 609		

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F 609	Continued From page 11 illness. In addition the policy directed staff to report all allegations of resident abuse, neglect immediately to the administrator and shall be reported to the appropriate state entity not later than two hours after the allegation is made.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate allegations of neglect for 1 of 1 residents (R7) who was alleged to have not received staff care for an extended period of time. Findings include: R7's quarterly MDS dated 7/27/23, indicated R7 was severely cognitively impaired had Alzheimer's	F 610	F610 Investigate, Prevent, Correct alleged violations. The facility does thoroughly investigate allegations of abuse and neglect to prevent and correct alleged violations. 1. All residents have the potential to be affected. 2. All Staff, including facility leadership were re-educated on the abuse and neglect policy/procedures and proper	10/16/23

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F 610	Continued From page 12 disease, dementia, anxiety, and depression. R7's Care Plan dated 8/23/23, indicated R7 requires assist of two with activities of daily living, requires two person assist with toileting and peri-care with every incontinent episode as necessary. During interview on 9/12/23 at 8:12 p.m., family member (FM)-F stated she had a camera put in R7's room two to three months ago due to noticing bed wetting and had concerns she was not getting changed after incontinent episodes of bowel and bladder. FM-F stated she had filled out a grievance forms and gave them to the director of nursing (DON) and the administrator and received no follow up on any of them. FM-F stated the only thing she noticed was a sign placed in R7's room to check and change every two hours and lay down after meals. Review of facility Resident Grievance Form's on R7 indicated the following: -On 8/18/23 Resident Grievance Form filled out by FM-F indicated, R7 was changed on 8/17/23 at 8:00 p.m. to 8:30 p.m. and not again until 8/17/23 in the morning she was not touched or changed for nine hours. The grievance form further indicated FM-F stated this was very concerning because she could have fell or passed away and no one checked on her all night until 5:34 a.m. The form indicated under investigation/outcome completed by the DON. Educated staff on respect, dignity, job performance expectations. Discussed checking and changing every two hours. Also placed signs in memory care unit. The form also indicated FM-A was notified of the outcome and was satisfied with the resolution. the	F 610	investigations for all types of abuse including neglect. The facility will continue to follow abuse allegation protocols to ensure the protection and safety of all residents 10/12/23. 3. A Care Conference was conducted with family members of R7 to ensure any grievances were addressed and any allegations of neglected identified to prevent the deficient practice from reoccurring. 4. Facility grievance program will be utilized to identify any potential allegations of abuse or neglect. 5. The Admin/Designee will audit facility grievances and abuse allegations to ensure policy and procedures are followed and protection of all residents with results forwarded to the QAA Committee for review. Audit Weekly X 4, Monthly X 6 Responsible Party: ADM/Designee	

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F 610	Continued From page 13 DON signed the form along with the administrator. During follow up interview on 9/12/23 at 8:30 p.m. FM-F stated there was an additional Grievance Form she filed on 8/18/23, which was informing the DON and the administrator R7 was not checked or changed on 8/18/23 from from 7:30 a.m. until 6:30 p.m. FM-A stated she went 11 hours without being checked or changed when camera was reviewed. FM-A further stated she was also informed by the evening staff when she was changed after supper and cheerios from breakfast were found in her incontinent brief. FM-A stated no one ever followed up with her on either grievance related to care concerns. FM-A also confirmed the facility never requested to review the footage as a part of an investigation or response to her concerns. During interview with the administrator on 9/18/23 at 1:00 p.m., stated he was not aware of the incident that occurred with the cheerios but was aware there was a camera in R7's room. The administrator then stated FM-A was always in the DON's office and was surprised there was never any resolution. The administrator stated the DON would not be in the facility for the rest of the week with a family emergency. The administrator stated he was unable to find the second grievance form. During interview on 9/20/23 at 6:30 p.m., with facility nurse consultant (FNC) stated a follow up and resolution should have been completed with the grievances. The FNC also stated an investigation should have been completed and looked into to see if abuse or neglect had occurred with each incident and then reported if needed.	F 610		

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F 610	Continued From page 14 The Grievance Forms lacked evidence an investigation was completed by the facility. A Nursing Facility Abuse, Prevention, Identification, Investigation and Reporting Policy updated 2/06/23, indicated after the incident is immediately reported to the state agency an investigation will be conducted.	F 610		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely incontinence care for 1 of 1 residents (R8) and bathing as care planned for 4 of 4 residents (R1, R29, R5 and R23) who were dependent upon staff for assistance with activities of daily living (ADL). Findings include: R8's annual MDS dated 9/08/23, indicated R8 was cognitively intact, needed extensive assist of two with toileting and always incontinent of bowel and bladder. The MDS further indicated she was not on a toileting plan. R8's Care Plan dated 9/08/23, indicated R8 needed assist of one with toileting, provide peri-care with every incontinent episode as necessary.	F 677	F677 ADL care provided for dependent residents The facility does ensure that residents who are unable to carry out activities of daily living receive necessary services to maintain good bathing and incontinence care. 1. R29, R5, and R23 are receiving their baths as scheduled. Their preferences have been reviewed and schedules updated accordingly. R1 Passed away. 2. R8 Observed to ensure incontinence care is completed routinely and timely. 3. All residents have the potential to be affected. 4. All resident bath schedules reviewed and updated accordingly. 5. Staff educated on providing baths per schedule and incontinence care routinely and timely, reporting refusals, and	10/16/23

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F 677	Continued From page 15 During observation and interview on 9/11/23 at 4:50 p.m., licensed practical nurse (LPN)-B stated R8 was last checked and changed at 1:50 p.m. and on the evening shift they like to toilet her every two hours or she was usually very wet with urine. LPN-B stated they only have two nursing assistants (NA) working on the floor and they are both very busy. LPN-B checked R8 and her pad was saturated in urine and had a pungent odor (3 hours after she was last checked). During interview on 9/20/23, at 8:54 p.m. R8's family friend (FF)-A stated they had filed grievances in the past time and time again and promises are made but not kept. FF-A stated there was not enough staff and she finds R8 many times sitting in a full day of feces and urine when she gets there after supper. R1's significant change Minimum Data Set (MDS) dated 8/25/23, indicated R1 was moderately cognitively impaired, required extensive assist of two with bed mobility and total assist of two with transfers. The MDS indicated R1 had limited mobility in upper and lower extremity and used a wheelchair for mobility. R1's care plan dated 8/17/23, identified R1 was bariatric and had peripheral vascular disease, inflammation of lower extremity, lack of coordination, abnormal posture significant pain management needs and on hospice care. The care plan indicated a two person assist with activity of daily living care and mechanical lift for transfers. Review of R1's Bath/Shower sheet indicated on 9/15/23, R1 did not receive a shower and no	F 677	appropriate documentation. 10/12/23 6. The DON/Designee will audit bath schedules and compliance daily X 2 months with results forwarded to the QAA Committee for review. 7. Routine Audits to ensure completion of routine and timely incontinence care provided daily X 1 month with results forwarded to the QAA Committee for review. Responsible Party: DON/Designee	

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F 677	Continued From page 16 reason was listed. R29's admission MDS dated 8/29/23, indicated R29 was severely cognitively impaired, required one person physical assist with ADL's and bathing. Review of R29's showers indicated on 9/04/23 and 9/07/23, R29 did not receive shower and no reason was listed. R5's quarterly MDS dated 7/07/23, indicated R5 was moderately cognitively impaired required extensive assist with ADL's and one person physical assist with bathing. Review of R5's showers indicated on 8/27/23, 9/1/23 and 9/15/23, R5 did not receive showers and no reason was listed. R23's significant change MDS dated 9/13/23, indicated R23 was cognitively intact required limited assist with dressing, extensive assist with personal hygiene and two person physical assist with bathing. Review of R23's showers indicated R23 did not receive a shower on 8/11/23 and 9/01/23 and no reason was listed. During interview on 9/11/23 at 3:44 p.m. NA-A stated she was working the evening shift tonight and right now they only have myself, a nurse and a TMA working. NA-A stated they have four scheduled showers tonight that require two assist and there was no way she will be able to complete all of the showers scheduled. NA-A stated it was not uncommon for the showers to get missed or not completed when there was not	F 677		

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F 677	Continued From page 17 enough help on the floor (two NA's). During interview on 9/12/23 at 11:00 a.m. director of nursing (DON) stated the showers should be completed and missed showers should be made up the follow day. The DON further stated she had been doing audits on the showers and thought they were getting done.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess 1 of 1 resident (R35) for change of condition upon family request. Findings include: R35's significant change Minimum Data Set (MDS) dated 9/01/23, indicated diagnosis of severe cognitive impairment, atrial fibrillation, coronary artery disease, end stage renal disease and hypertension. The MDS indicated R35 required extensive assist of two with dressing, bathing, and grooming. R35's care plan dated 7/15/23, indicated at risk for fluid overload, chest pain, weakness and	F 684	F 684 quality of care The facility does assess residents for change of condition and report changes to the primary care provider. 1. R 35 has passed away 2. All residents have the potential to be affected and will receive appropriate nursing services with accurate assessment and timely intervention for acute changes of condition with timely notification to physician when changes of condition occur. 3. All licensed nurses were educated on the identification, assessment, and notification of resident changes of condition per facility policies. In addition,	10/16/23

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F 684	Continued From page 18 cardiovascular disease. The care plan directed staff to monitor for increased blood pressure, shortness of breath, signs of acute renal failure and to monitor/document and report to the physician. The care plan also indicated R25 had a staph infection to his right knee and was on antibiotics. During interview on 9/11/23 at 7:05 p.m., family member (FM)-B stated on 8/25/23, R35 was not acting like himself and was very confused and was normally alert. FM-B stated R35 stated to her that he could not remember where he was at and thought he was back home. FM-B stated her and FM-A knew something was wrong with R35 since he was normally able to identify where he is. FM-B stated she got off of the phone with R35 and called the facility for two hours straight with out getting a hold of anyone, when R35 received his lunch tray R35 told FM-B he did not know what the spoon, knife or fork was for and did not know how to eat. FM-B stated she was finally able to get a hold of licensed practical nurse (LPN)-C and the nurse had no idea what was going on with him and did not appear to know he had cellulitis in his foot. FM-B further stated LPN-C told me he was just a little confusion, and FM-B stated she said it was more than that. During interview on 9/12/23 at 11:55 a.m., FM-A stated on the morning of 8/25/23, she spoke to R35 and he was very confused. FM-A stated she was worried since he was normally alert and oriented. FM-A stated she spoke to trained medical assistant (TMA)-A who told her he appeared a little confused. FM-A stated it was devastating and she was very stressed over it and scared because back last year he had the same symptoms and then had a heart attack.	F 684	education provided on timely follow up of resident concerns regarding changes of condition voiced by family members. 10/12/23 4. Nursing leadership educated on the review of clinical progress notes to ensure timely follow up and physician notification on resident changes of condition. 10/12/23 5. Nursing leadership to audit progress notes daily and review with IDT in the morning clinical quality conference. Results forwarded to QAA Committee for review. Responsible Party: DON/Designee	

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F 684	Continued From page 19 FM-A stated TMA-A then told me he could have had a stroke and that happened all the time, that is when she asked her to go check on him again. FM-A stated she called again the next day (8/26/23) in the morning and spoke to registered nurse (RN)-A and RN-A only new R35 had a little confusion the day before. FM-A indicated she was very upset no one took the time to look at R35 or assess him to see if he was okay. FM-A stated on 8/29/23, R35 was sent to the hospital with concerns of low oxygen and they found out he had a heart attack and was discharged back to the facility on 8/30/23 on hospice and passed away on 9/04/23. Hospital Discharge Summary dated 8/30/23, indicated R35 was admitted on 8/29/23 and discharged on 8/30/23, and diagnosed with acute myocardial infarction (commonly known as a heart attack, occurs when blood flow decreases or stops in one of the coronary arteries of the heart, causing damage to the heart muscle). In addition, the discharge summary indicated R35 will be discharging on hospice care and prognosis is terminal with expected death in days to weeks. Review of R35's Progress Notes indicated the following on 8/25/23 when family had concerns of R35's change in condition: -On 8/25/23 at 1:45 p.m., R35 noted to be more confused today. FM-B called concerned about this. R35 stated to LPN-C he doesn't know where he is or what he should be doing. Writer reassured R35 many times which helped for a little while then he would ask again. Will continue to monitor. Also told [FM-B] we would call her if there was any big changes.	F 684		

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F 684	Continued From page 20 During interview on 9/12/23 at 4:18 p.m., TMA-A stated FM-A called and wanted to know what was going on with R35 and was upset he was confused and did not know how to eat his lunch. TMA-A stated she shared with FM-A she heard in report R35 was showing signs of confusion. TMA-A stated she was unaware if his physician was notified of his confusion and FM-A asked what could cause confusion and TMA-A stated she told FM-A that it could be from a urinary tract infection or transient ischemic attack (TIA) a mini stroke but that they (the residents) usually come back to normal and it happens more often than you'd think with the elderly. TMA-A stated she told the overnight nurse about the call but she only worked a half shift and then another nurse came on and maybe it never got passed on. During interview on 9/13/23, at 12:16 p.m., director of nursing (DON) stated she worked on 8/27/23, evening shift and visited with R35's family and read what was charted and R35's family never expressed any concerns to her. During interview on 9/20/23, at 2:00 p.m. LPN-C stated she was working on 8/25/23 when FM-A called about R35 and stated she was busy that day and there was not enough staff to allow me complete an assessment on R35. A policy was requested but was not provided.	F 684		
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	F 689		10/16/23

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F 689	Continued From page 21 §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 investigate and respond to a Hoyer lift incident before placing the Hoyer lift back into care service for 1 of 2 (R2) residents. Additionally, the facility failed to have a system to perform regular maintenance on resident ceiling lift and failed to respond to voiced concerns by nursing staff related to ceiling lift malfunction and safety related to care planned two person Hoyer lift for 1 of 2 (R1) resident viewed for accidents. This resulted in an immediate jeopardy (IJ) situation for R2 and R1. The IJ began on 7/30/23 at 8:22 a.m., when a Hoyer lift being used to transfer R2 would "not stop" and a different Hoyer lift had to be used to complete the transfer. The Hoyer lift was placed out of service for a short period but returned to service before the facility completed an internal investigation or contacted the manufacturer for direction. Additionally, the facility failed to have a system for routine maintenance related to a ceiling lift used to transfer R1 which had ongoing staff reports of malfunction over the last six months and failed to reassess R1's safe transfer in a Hoyer lift, both potentially causing R1 discomfort and pain. The DON and administrator were notified of the IJ on 9/14/23, at 5:35 p.m. The IJ was removed on 9/15/23, at 5:35 p.m. but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy.	F 689	F689 Free of Accident Hazards/Supervision/Devices All residents residing at Glen Oaks have the potential to be affected by the deficient practice. 1. R2□s care plans reviewed to reflect accurate transfer status. R1 Passed away 2. All residents have the potential to be affected. 3. All mechanical lifts inspected and all defective lifts removed from resident care areas. 4. All ceiling lifts locked out until which time a manufactures inspection can be completed. 5. All Nursing staff educated on proper use of mechanical lifts and transfers. No nursing staff will operate mechanical lifts until education is completed prior to working next shift. 6. Maintenance Director educated on routine maintenance guideline per manufacturers recommendation. 7. All licensed staff educated on manufacturers recommendation for utilization of mechanical lifts. 8. Maintenance Director educated by the Administrator on the process for mechanical lift concerns/maintenance and repairs to include process for removal of defective mechanical lifts from care areas. 9. All staff educated on the process for identifying, reporting, investigating, and	

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F 689	Continued From page 22 Findings include: R2's annual MDS dated 8/23/23, indicated R2 was cognitively intact, required extensive assist of two with bed mobility, transfers, impairment on upper extremities and used a wheelchair for mobility. R2's Care Plan dated 8/29/23, indicated R2 had spinal Stenosis (narrowing of the spinal canal in the lower part of back), osteoporosis, edema, and lower back pain. Care plan further indicated R2 transferred with assist of two and mechanical lift. 9/12/23-9/15/23, R1 was in the hospital and unable to be observed or interviewed. Incident Report dated 7/30/23 at 8:22 a.m., indicated R2 was being transferred by two staff and Hoyer lift out of bed. Resident was being lowered down and Hoyer lift would not stop. R2 ended up sitting in sling about a foot off the ground; the Hoyer would "not stop" when stop button was pushed, needed another Hoyer to complete transfer. The report indicated staff assisted resident with another Hoyer lift and four staff to place resident in her wheelchair. Hoyer machine was taken off the floor and a repair slip completed for maintenance. Report indicated no injuries occurred to R2. During interview on 9/13/23 at 7:00 p.m., NA- B stated on 7/30/23, she was transferring R2 with the Hoyer lift out of bed when the lift automatically just started to lower to the ground, NA-B stated R2 had jerking movements with her body and maybe that caused the lift to lower on its own. NA-B also stated with R1 they have had issues	F 689	tracking issues with mechanical lifts. 10. Director of Clinical Services (DCS) educated Director of Nursing (DON) on follow up on root cause analysis for all incidents to ensure proper intervention implemented. All education provided as part of facility abatement plan on 9/14/23 Facility QAA Committee will review any concerns with mechanical lifts weekly X 4, and monthly X 6. Responsible Party: ADM/Designee	

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F 689	Continued From page 23 with the ceiling lift battery not charging and she had told the MND several times and he just told us to make sure we have the battery on the charger correctly. NA-B stated we tried that, and it doesn't charge the battery. During interview on 9/14/23 at 8:07 a.m., MND stated he was aware of the incident with R2 and looked over the Hoyer lift but was unable to find anything wrong with the lift, so he put the lift back on the floor for staff to use. The MND confirmed he never called the manufacturer to see if it was safe to put back on the floor despite the manufacturer primarily working with the lifts, completing the maintenance on a routine basis and all the lifts having just been checked two weeks prior to the incident. The MND did state he had never called the manufacture for a concern since they come out every 6 months to do their safety checks and maintenance on them. During interview on 9/14/23 at 8:30 a.m., director of nursing (DON) stated she was aware of the incident with R2 and the lift lowering R2 to the floor. DON added, since MND looked at the lift and was unable to find anything wrong, she felt there was no reason to complete an investigation on the incident. During interview on 9/14/23 at 9:14 a.m., EZ Way Service and Sales Support staff stated the EZ Way Hoyer lift should have been removed from the floor and not been put back onto the floor until calling EZ Way, due to the possibility of brake failure of the machine and needing to complete two checks over the phone and if that did not work a technician might need to come out to look over the machine.	F 689		

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F 689	Continued From page 24 During interview on 9/14/23 at 10:00 a.m. EZ Way representative (R)-A stated the facility had preventive maintenance done on the EZ Way lifts and stands on 9/20/22 and then on 7/17/23 and 7/18/23. The R-A stated the facility should have had preventative maintenance done in March 2023 but was not scheduled. EZ Way, INC. Service Manual revised 7/11/22, indicated the manufacturer suggests that the following components and operating points be scheduled for inspection at intervals not greater than six months. Any detected deficiency must be rectified before the lift is put back into service. R1's significant change Minimum Data Set (MDS) dated 8/25/23, indicated R1 was moderately cognitively impaired, required extensive assist of two with bed mobility and total assist of two with transfers. The MDS indicated R1 had limited mobility in upper and lower extremity and used a wheelchair for mobility. R1's care plan dated 8/17/23, identified R1 was bariatric and had peripheral vascular disease, inflammation of lower extremity, lack of coordination, abnormal posture, significant pain management needs and was on hospice care. The care plan indicated a two person assist with activity of daily living care and mechanical lift for transfers. On 9/12/23 at 12:43 p.m., during observation and interview R1 was observed being transferred from wheelchair to bed using a ceiling lift by nursing assistant (NA)-C, NA-D and trained medical aide (TMA)-B. R1 was several inches off her wheelchair when the ceiling lift stopped, staff were observed working with the remote to get the	F 689		

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F 689	Continued From page 25 lift working. R1 was observed to be jerked up and down by the lift during this time and yelling out, "ouch" and was crying. Staff stopped and put her back in chair. Staff reported they told leadership the ceiling lift was not working, "again." Per interviews with (NA)-C, NA-D and (TMA)-B the ceiling lift had not been functioning correctly for over six months. Staff expressed they believed R1 preferred the ceiling lift, and it was safer and more comfortable for her to use than the EZ Way Hoyer Lift. The staff stated when they have used the Hoyer lift in the past some of them have had to stand on the legs of the lift to prevent it from tipping over. Additional concerns the staff expressed included the ceiling lift stopping and jerking R1, causing her unnecessary pain during transfers. They expressed this was something that had been ongoing despite complaints they had made to leadership and requests for repairs to maintenance. When they put maintenance request in, MND would instruct them to put the battery on the charger tilted or crooked to get it to charge, which was not a sustainable solution. During same observation surveyor attempted to interview R1 but she was not interviewable. A second observation and interview on 9/12/23 at 1:10 p.m., during transfer from the wheelchair to her bed using the EZ Way Hoyer Lift. The MND was asked by facility leadership to demonstrate how to use the EZ Way Hoyer Lift safely with R1. MND and NA-C, NA-D and TMA-B were observed hooking R1 up to the EZ Way Hoyer Lift from her wheelchair, bed was in low position, MND was running the EZ Way Hoyer Lift while the aids were guiding R1. When R1 was in the air, the EZ Way Hoyer Lift wheel was observed to lift off the ground two inches and the transfer had to be halted due to the bed being in the wrong	F 689		

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F 689	Continued From page 26 placement position for transfer (bed in low position), which caused R1 to yell out in pain. Interview with DON confirmed the transfer with R1 was not completed the way she would have transferred R1. According to manufacturer during an interview on 9/14/23 at 3:30 p.m., the EZ Way Hoyer Lift is not safe or stable to use if the wheels are not all on the ground during transfers and if the wheels are lifting off the ground, this could be because of a bent frame or broken bolt(s). After observation of resident transfer on 9/12/23, at 1:10 p.m. Hoyer was not removed from resident care and staff were not immediately retrained. A Physical Therapy Treatment Encounter Note indicated an evaluation was completed on 9/13/23 with R1 which indicated, "...Physical Therapy recommends a minimum of three staff for Hoyer transfers and that staff move Hoyer lift slowly for resident comfort and safety." During interview on 9/13/23 at 11:52 a.m., DON stated the MND does the training with the staff on the Hoyer lifts and assumed he received training from the EZ Way. The DON stated the MND was not a NA or trained in patient care and should not have had him transfer R1. During interview on 9/13/23 at 2:34 p.m., MND stated he encouraged staff to scan the QR code on the lifts and watch the video for training on the lifts. The MND stated he had not received training from EZ Way to transfer residents in the Hoyer lifts.	F 689		

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F 689	Continued From page 27 During interview on 9/15/23 at 9:00 a.m., MND stated the ceiling lifts were purchased from Direct Supply company but he was told by corporate they were no longer working with Direct Supply for the ceiling lift (for approximately a year and a half) so he was not able to purchase replacement batteries for the lift. MND stated he was not aware of any contracted routine maintenance for the ceiling lift and confirmed he had not completed any routine maintenance on the lift himself but had directed staff to put the battery on the charger different ways to get it to charge better. During interview 9/20/23 at 6:20 p.m., the facility nurse consultant stated she had been the consultant with the facility for the past year and was not aware the ceiling lift was being used for resident care. The IJ that started on 7/30/23 was removed on 9/15/23, when it was verified through observation, interview and document review the facility removed the Hoyer lift and ceiling lift from resident care pending inspection/routine maintenance check, retrained staff on safe transfers with the EZ Way Hoyer lifts and reviewed policies and procedures to ensure alignment with regulatory standards. All staff were educated on the procedures.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 725		10/16/23

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F 725	Continued From page 28 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide sufficient nursing staff to meet assessed needs for 5 of 5 residents (R8, R1, R29, R5 and R23) reviewed for activities of daily living (ADLs); quality of care for 1 of 1 (R35) residents reviewed for nursing assessement; 9 of 9 residents (R7, R10, R11, R15, R16, R17, R18, R22 and R25) reviewed for supervision in a memory care unit; RN coverage; and as expressed by Resident Council, Staff, and 2 family members (FM-D and FM-E) who had concerns about the lack of sufficient nursing staff at the nursing home. Findings include:	F 725	F725 Sufficient nursing staff The facility does provide sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety entertainer, maintain the highest, practical physical, mental, and psychological well-being of each resident. 1. All residents have the potential to be affected. 2. All nurse managers were educated on reviewing and rescheduling baths to ensure compliance. 10/12/23 3. All CNA□s educated on the need to ensure baths are completed per schedule	

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F 725	Continued From page 29 ASSESSED NEEDS NOT MET: R1's significant change Minimum Data Set (MDS) dated 8/25/23, indicated R1 was moderately cognitively impaired, required extensive assist of two with bed mobility and total assist of two with transfers. The MDS indicated R1 had limited mobility in upper and lower extremity and used a wheelchair for mobility. R1's care plan dated 8/17/23, identified R1 was bariatric had peripheral vascular disease, inflammation of lower extremity, lack of coordination, abnormal posture significant pain management needs and on hospice care. The care plan indicated a two person assist with activity of daily living care and mechanical lift for transfers. A Physical Therapy Treatment Encounter Note indicated an evaluation was completed on 9/13/23, with R1 which indicated "...Physical Therapy recommends a minimum of three staff for Hoyer transfers and that staff move Hoyer lift slowly for resident comfort and safety." During interview on 9/21/23 at 2:35 p.m., TMA-E stated she worked on Sunday 9/17/23, and since there was not enough staff on the day shift they were unable to get R1 out of bed for the day. R8's annual MDS dated 9/08/23, indicated R8 was cognitively intact, needed extensive assist of two with toileting and always incontinent of bowel and bladder. The MDS further indicated she was not on a toileting plan. R8's Care Plan dated 9/08/23, indicated R8 needed assist of one with toileting, provide	F 725	and concerns to be communicated to the nursing leadership team. 10/12/23 4. The DON/designee will audit bathing schedule daily, and any baths not given will be rescheduled to ensure completion within the week. Audits will be completed daily times seven, weekly times four, and monthly times three with results reviewed by the QA committee. 5. Contracts obtained with local staffing agencies to assist the facility in providing adequate staff with the appropriate competencies and skill sets. 6. Job Postings updated and boosted on all social media and job posting websites to include new hire incentives. 7. Routine assessment of staff availability with our campus assisted living leadership team to identify potential team members to assist with staffing in the SNF. 8. Daily staffing calls have been scheduled with the facility and Campbell Street Services Support Team to assist with identifying the staffing needs and acuity levels of the facility for the for seeable future. 9. Facility staff shift pick up bonus program reviewed and provided to staff. 10. Staffing patterns and facility acuity levels reviewed by Campbell Street Services Support Team and increases made to facility staffing grid to accommodate identified increased acuity levels. 11. Staffing levels and acuity discussed daily at the morning Clinical Quality Conference with schedule modified as appropriate, results forwarded to the QAA Committee for review.	

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F 725	Continued From page 30 peri-care with every incontinent episode as necessary. During observation and interview on 9/11/23 at 4:50 p.m. licensed practical nurse (LPN)-B stated R8 was last checked and changed at 1:50 p.m. and on the evening shift they liked to toilet her every two hours or she was usually very wet with urine. LPN-B stated they only have two NAs working on the floor and they are both very busy. LPN-B checked R8 and her pad was saturated in urine and had a pungent odor to it (3 hours after she was last checked). During interview on 9/20/23, at 8:54 p.m. R8's family friend (FF)-A stated she had filed grievances in the past time and time again and promises were made but not kept. FF-A stated there is not enough staff and she finds R8 many times sitting in a full day of feces and urine when she gets there after supper time. MISSED SHOWERS: R1's care plan dated 8/17/23, identified R1 was bariatric and had peripheral vascular disease, inflammation of lower extremity, lack of coordination, abnormal posture significant pain management needs and on hospice care. The care plan indicated a two person assist with activity of daily living care and mechanical lift for transfers. Review of R1's Bath/Shower sheet indicated on 9/15/23, R1 did not receive a shower and no reason was listed. R29's admission MDS dated 8/29/23, indicated R29 was severely cognitively impaired, required one person physical assist with ADL's and	F 725	Responsible Party: ADM/DON/Designee	

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F 725	Continued From page 31 bathing. Review of R29's showers indicated on 9/04/23 and 9/07/23, R29 did not receive shower and no reason was listed. R5's quarterly MDS dated 7/07/23, indicated R5 was moderately cognitively impaired required extensive assist with ADL's and one person physical assist with bathing. Review of R5's showers indicated on 8/27/23, 9/1/23 and 9/15/23, R5 did not receive showers and no reason was listed. R23's significant change MDS dated 9/13/23, indicated R23 was cognitively intact required limited assist with dressing, extensive assist with personal hygiene and two person physical assist with bathing. Review of R23's showers indicated R23 did not receive a shower on 8/11/23 and 9/01/23 and no reason was listed. During interview on 9/11/23 at 3:44 p.m., NA-A stated she was working the evening shift tonight and they only had myself, a nurse and a TMA working. (confirmed with schedule) NA-A stated they have four scheduled showers tonight that required two assist and there was no way they will be able to complete all four showers. NA-A stated it was not uncommon for the showers to get missed. SEE F677 Quality of Care: R35's significant change Minimum Data Set (MDS) dated 9/01/23, indicated diagnosis of	F 725		

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F 725	Continued From page 32 severe cognitive impairment, atrial fibrillation, coronary artery disease, end stage renal disease and hypertension. The MDS indicated R35 required extensive assist of two with dressing, bathing, and grooming. During interview on 9/11/23 at 7:05 p.m., family member (FM)-B stated on 8/25/23, R35 was not acting like himself and was very confused and was normally alert. FM-B stated R35 stated to her that he could not remember where he was at and thought he was back home. FM-B stated her and FM-A knew something was wrong with R35 since he was normally able to identify where he is. FM-B stated she got off of the phone with R35 and called the facility for two hours straight with out getting a hold of anyone, when R35 received his lunch tray R35 told FM-B he did not know what the spoon, knife or fork was for and did not know how to eat. FM-B stated she was finally able to get a hold of licensed practical nurse (LPN)-C and the nurse had no idea what was going on with him and did not appear to know he had cellulitis in his foot. FM-B further stated LPN-C told me he was just a little confusion, and FM-B stated she said it was more than that. During interview on 9/20/23, at 2:00 p.m. LPN-C stated she was working on 8/25/23 when FM-A called about R35 and stated she was busy that day and there was not enough staff to allow me complete an assessment on R35. SEE F684 MEMORY CARE UNIT DOOR PROPPED OPEN: Supervision During interview on 9/18/23 at 2:00 p.m., LPN-B stated "the weekend was horrible on Saturday 9/16/23, there was only me as the charge nurse,	F 725		

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F 725	Continued From page 33 a TMA and a NA scheduled to work. (confirmed with schedule) I received permission from the administrator to prop open the locked memory care unit doors open." LPN-A stated the doors were propped open from 2:00 p.m. until 6:00 p.m. when the activity aide came in and was able to sit with the residents and do activities with them. LPN-B stated luckily none of the residents eloped during that time. LPN-B stated there are nine residents in the unit and many have behaviors and some of them had recent resident to resident physical incidents. LPN-B stated the front door of the building was alarmed if a resident attempted to leave. The following nine residents resided in the memory care unit: R7's quarterly MDS dated 7/27/23, indicated R7 was severely cognitively impaired, had Alzheimer's, dementia, anxiety, and depression. The MDS further indicated R7 had physical behavioral symptoms directed toward others and wandered. R10's significant change MDS dated 9/12/23, indicated R10 had dementia and was severely cognitively impaired, had physical, verbal, and other behavioral symptoms such as hitting toward others or scratching and pacing. The MDS indicated rejection of care and wandering. R11's quarterly MDS dated 9/20/23, indicated R11 was moderately cognitively impaired and had fractures and other multiple trauma. The MDS further indicated R11 had physical behaviors of hitting kicking towards others, rejection of care and wandering.	F 725		

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F 725	Continued From page 34 R15's quarterly MDS dated 8/03/23, indicated R15 was cognitively intact and had progressive neurological conditions, Alzheimer's, and dementia. The MDS also indicated R15 had verbal behaviors. R16's quarterly MDS dated 9/15/23, indicated R16 was moderately cognitively impaired and had dementia and schizophrenia. The MDS also indicated R16 had physical and verbal behaviors, rejects care and wanders. R17's quarterly MDS dated 9/15/23, indicated R17 was severely cognitively impaired and had dementia and non-traumatic brain dysfunction. The MDS further indicated R17 had physical behaviors and wandered. R18's quarterly MDS dated 8/26/23, indicated R18 was severely cognitively impaired, had Alzheimer's disease. The MDS further indicated R18 wandered. R22's quarterly MDS dated 9/01/23, indicated R22 was severely cognitively impaired, had Alzheimer's and dementia. The MDS indicated R22 would reject care. R25's quarterly MDS dated 9/15/23, indicated R25 was severely cognitively impaired, had non-traumatic brain dysfunction and dementia. The MDS further indicated R25 would reject care. RN Coverage: On 9/09/23 and 9/10/23, the facility had no RN coverage for both days. Interview on 9/11/23 at 2:00 p.m., the director of nursing (DON) stated she was not aware there	F 725		

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F 725	Continued From page 35 was no RN coverage over the weekend but that was probably correct. During interview on 9/12/23 at 3:00 p.m., the human resource director and admissions assistant stated the staffing coordinator has been on a leave of absence and they have been in charge of the scheduling and did not realize they had no RN coverage over the past weekend. Although the RN on-call should have covered those hours. SEE F727 RESIDENT COUNCIL: Review of resident council meeting minutes for the last three months indicated the following: 7/06/2023 New Concerns with staffing: -Have to wait to go to the bathroom so long that it becomes to late -EZ stand is not available to go to the bathroom and never returned -resident left in the dinning room for an hour -Call light left on for 1 hour and 15 minutes 8/03/2023 Follow up to concerns from 7/06/23: -Have to wait to go to the bathroom so long that it becomes to late (still an issue 8/03/23) -EZ stand is not available to go to the bathroom and never return (still an issue 8/03/23) -Left in the dinning room for an hour (still an issue 8/03/23) -Call light left on for 1 hour and 15 minutes (call lights still an issue 8/03/23) New Concerns with staffing: -Room trays delivered 30 to 40 minutes late	F 725		

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F 725	Continued From page 36 -Not enough staffing and staff working tell the residents they are short 9/12/23 Follow up to concerns from 7/06/23: -Have to wait to go to the bathroom so long that it becomes to late (still an issue 9/12/23) -EZ stand is not available to go to the bathroom and never return (not mentioned) -Left in the dinning room for an hour (still an issue 9/12/23, but improving) -Call light left on for 1 hour and 15 minutes (call lights still an issue 9/12/23) Follow up to concerns from 8/03/23: -Room trays delivered 30 to 40 minutes late (not mentioned) -Not enough staffing and staff working tell the residents they are short (still an issue 9/12/23) New Concerns with staffing: -Call lights turned off and aides tell them will be back in 2 minutes and return 20 minutes later STAFF CONCERNS: During interview on 9/11/23 at 2:35 p.m., LPN-B stated she works the evening shift as the charge nurse and was the only licensed staff in the building for 34 residents. LPN-B stated she was responsible for passing medications, taking phone calls and assisting the aides on the floor. In addition LPN-B stated nurse management was never available on the weekends when they are on-call and they have no support from them. In addition, LPN-B stated showers are not getting completed like they should be and family members are getting angry with staff because cares are not getting done. LPN-B stated she has reported all of this to management and nothing	F 725		

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F 725	Continued From page 37	F 725		

seems to get done to make it better.

During interview on 9/18/23 at 4:06 p.m., NA-A stated she had told management the residents need better care, here and last night baths were not done and we get yelled at that our work is not done. NA-A stated yesterday evening the residents also had to eat in their rooms because there was not enough staff to bring them down to the dining room and several of them were upset.

During interview on 9/18/23 at 7:25 p.m., LPN-C stated the staffing was terrible over the weekend and on Sunday 9/17/23, LPN-C stated she was the only nurse in the building and was told R10 hit another resident in the face by the trained medical assistant TMA-B. LPN-C stated she was so busy giving insulin's that morning she was unable to assist with the incident and did not have time to do any charting on it.

FAMILY CONCERNS:
During interview on 9/19/23 at 4:01 p.m., FM-D stated he visits R12 three times a day and does not feel there is adequate staffing at the facility. FM-D stated last weekend there was not enough staff and R12 had to eat supper in her room and again last night. FM-D stated every morning when he comes to visit R12 she was always waiting in the doorway of her room to use the bathroom and when they put her on the toilet she often has to wait over 30 minutes to be taken off. FM-D stated he goes home in a bad mood and sometimes he sheds tears over it and stated, sometimes I wonder when the staff go home at night if they worry too?" FM-D stated the staff do work very hard, they just don't have enough of them.

During interview on 9/20/23 at 11:00 a.m., FM-E

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F 725	Continued From page 38 stated he visits R4 and in the evening many times when R4 had to go to the bathroom and when her call light was put on it could take staff 30 to 45 minutes to answer the call light and that was too long, R4 could not wait that long. FM-E stated he does not think the staff does that on purpose there just was just not enough staff to help. In addition, FM-E stated twice last week R4 had to eat supper in her room because they did not have enough staff. FM-E further stated he was impressed with the staff they have, adding they are very good. During interview on 9/13/23 at 12:14 p.m., DON stated the facility had adequate staffing and according to corporate, they have the largest amount of staff hours compared to other buildings. The DON stated the facility can staff with one nursing assistant to 10 residents. During interview on 9/19/23 at 1:20 p.m., administrator stated the staffing was not ideal and they try to come in to provide support to the staff. The administrator further stated it was possible they don't always have RN coverage and they attempt to use supplemental nursing staff from agencies but they are often not able to help. The administrator stated he did allow the memory care door to be propped open when there was not enough staff but only to make sure staff had supervision on all of the memory care residents at all times. The administrator also stated he was aware they were having difficulties with the on-call nurse coming in on the weekends during staffing issues and one of there RN's just put in her resignation and the other one has been on maternity leave but will be coming back in October. Administrator further stated they just hired a new LPN and they are constantly running	F 725		

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F 725	Continued From page 39 adds for help. Facility Staffing Policy revised October 2017, indicated "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plan." In addition the policy indicated staffing numbers and skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. Inquires or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee.	F 725		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours a day for a weekend when there was no RN scheduled. Findings include:	F 727	F727 RN 8hrs/7days/Week. Full Time DON 1. All residents have the potential to be affected 2. DON/Nursing leadership were educated regarding the requirement of 8	10/16/23

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F 727	Continued From page 40 Review of the facility schedule identified no RN coverage as follows: On 9/09/23 and 9/10/23, the facility had no RN coverage for both days. Interview on 9/11/23 at 2:00 p.m., the director of nursing (DON) stated she was not aware there was no RN coverage over the weekend but that was probably correct. During interview on 9/12/23 at 3:00 p.m., the human resource director and admissions assistant stated the staffing coordinator has been on a leave of absence and they have been in charge of the scheduling and did not realize they had no RN coverage over the past weekend. Although the RN on-call should have covered those hours. During interview on 9/12/23 at 4:00 p.m., licensed practical nurse (LPN)-B stated she called the RN on-call and no one answered the phone until finally LPN- E answered and was unable to come in, eventhough she was not even a RN. LPN-B stated it was not uncommon for the on-call RN not to answer or common in to assist with staffing issues at the facility. Facility policy Nurse Manager on Call dated 1/10/23, indicated "The 4 Nurse Managers consist of Director of Nursing, the Assistant Directors of Nursing, and the Clinical Day Supervisor". Nurse Managers will be on an "On-Call" rotation schedule consisting of 1 week in every four weeks, including weekends- Monday to Monday. The responsibility to being on-call includes the potential of providing emergency	F 727	hours of consecutive RN coverage 7 days per week. 3. DON/Nursing leadership will monitor daily schedules for scheduled RN staff to ensure RN coverage meets the requirement. 4. Audits forwarded to the QAA committee for review. Responsible Party: DON/Designee	

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F 727	Continued From page 41 coverage inside the facility in the event of a staffing need, on the designated weekend of being on-call. In addition the policy indicated not responding to the on-call needs can lead to disciplinary action, as lack of response can potentially impact the safety and well-being of residents and staff. The policy had signatures of the DON, ADON-A, ADON-B and Clinical day supervisor (LPN)-E.	F 727		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess, develop and implement a person centered dementia care treatment plan for 1 of 2 residents (R10) reviewed who had behaviors related to dementia and multiple resident to resident abuse incidents. Findings include: R10's significant change Minimum Data Set (MDS) dated 9/12/23, indicated R10 had dementia and was severely cognitively impaired, had physical, verbal, and other behavioral symptoms such as hitting toward others or scratching and pacing. The MDS indicated rejection of care and wandering. R10's care plan dated 8/22/23, indicated R10 had potential for episodes of alteration in mood as	F 744	F744 Treatment/Services for Dementia The facility does assess, develop, and implement a person center plan of care for dementia residents. 1. All residents have the potential to be affected. 2. R10 Plan of Care reviewed and update to reflect interventions for resident behaviors to prevent resident to resident abuse. 3. Behavior monitoring added to R10 orders for Q shift monitoring. 4. R10 MD notified for medication review. 5. Referral made to Deer Oaks for psychological services 6. RCA completed with facility staff assigned to memory care unit to determine R10 routine and likes/dislikes	10/16/23

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F 744	Continued From page 42 evidenced by persistent anger with staff or others, unrealistic fears, sad, crying and hallucinations and delusions. The care plan directed for behavioral psychological consults as indicated, monitor document mood to determine external cause, observe for signs of depression, hopelessness, mania, hypomania, increased irritability, frequent mood changes, agitation and hyperactivity. R10's care plan further indicated receives anti-psychotic and antidepressant medications and to monitor for side effects. A Incident Report dated 9/11/23, indicated on 9/11/23 at 5:25 p.m. R10 and another resident who resides in the memory care unit began yelling at each other over coffee cups in the cabinet. R10 hit the resident on the right shoulder, residents were separated and calmed down. The report indicated no physical injuries or emotional stress to either resident occurred from the incident. The incident report indicated action to prevent re-occurrence is to re-direct as needed with continued monitoring of the Memory Care area, intervene when noticing the two residents wanting the same items to help prevent a conflict from arising. During interview on 9/18/23 at 2:00 p.m., licensed practical nurse (LPN)-B stated on Sunday 9/17/23, during the day shift she heard in report R10 hit another resident. LPN-B stated something needs to be done with R10 because her behaviors were increasing and she had asked LPN-A, her primary nurse to call her physician and it never gets done. During interview on 9/18/23 at 7:25 p.m., LPN-C stated the staffing was terrible over the weekend and on Sunday 9/17/23, LPN-C stated she was	F 744	to assist with resident behaviors. 7. Activity Director to provide increased activities on memory care unit to assist with resident behaviors. 8. Staff educated on Dementia and Challenging Behaviors. 10/12/23 9. Nursing Leadership educated on the completion of RCA to determine appropriate interventions for residents with behaviors to prevent resident to resident altercations. 10. DON/Designee to audit progress notes and incident reports daily to identify resident behaviors and provide RCA and intervention and forward results to QAA Committee for review. Responsible Party: DON/Designee	

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F 744	Continued From page 43 the only nurse in the building and was told R10 hit another resident in the face by the trained medical aide (TMA)-B. LPN-C stated she was so busy giving insulin's that morning she was unable to assist with the incident and did not have time to do any charting on it. During interview on 9/19/23 at 9:07 p.m., TMA-B stated she worked in the memory care unit on 9/17/23, and while assisting another resident she heard R10 yelling at another resident, accusing her of stealing her baby. TMA-B then stated she saw R10 grab the resident by her hair and holding her head hitting her with a closed fist repeatedly three times. TMA-B stated she was able to get the resident, help her back to her room and lay her down. Adding she did not notice any injuries and walkied for help and after waiting three minutes and not getting a response, she propped open the kitchen door and yelled for someone to get the nurse. TMA-B stated the nurse still did not come for an hour and then asked what happened, gave another resident insulin and then left. During interview on 9/20/23 at 9:17 a.m., administrator stated the staff had a huddle meeting at shift change on 9/17/23, and he was called into the huddle and when he passed through the memory care he heard there was a verbal argument with R10 and another resident and asked if there were any injuries and I was told no. The administrator stated there was no documentation, so he thought nothing of the incident. During interview on 9/20/23 at 10:43 a.m., LPN-A stated he had noticed R10 was experiencing some hallucinations, more like pretending she is	F 744		

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F 744	Continued From page 44 smoking a cigarette or throwing something but her doctors would not prescribe anything psychological for her and the last time they tried to get someone in for psychological services it took months and months. When asked if there were other interventions attempted, LPN-A stated not that I know of. During interview on 9/20/23 at 1:00 p.m., LPN- E stated they do not have any behavior monitoring for R10's behaviors or any listed interventions for staff to attempt to use to reduce R10's behaviors. In addition, they do not have any psychological services set up for R10 because in the past with other residents it has taken up to a year to have a resident to be seen and to have them sent in there needs to be a lot of documentation to prove there was a concern with the resident. A policy was requested on dementia care with behaviors and was not received.	F 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		10/16/23

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F 755	Continued From page 45 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an antiparkinson medication was administered in accordance with physician orders for 1 of 1 residents (R5) who was provided Carbidopa-Levodopa (assists to relieve Parkinson's disease symptoms) outside of ordered parameters during a medication pass observation. Findings include: R5's quarterly Minimum Data Set (MDS), dated 7/7/23, indicated R5 was moderately cognitively impaired with a diagnosis of dementia and Parkinson's. R5's Order Recap Report identified R5 was ordered the following: -Carbidopa-Levodopa 25/100 mg (milligrams),	F 755	F755 Pharmacy Srvcs/Procedures/Pharmacist/Records The facility does ensure an anti-Parkinson medication are administered in accordance with physicians orders. 1. R 5 and their Physician have been informed of the prior Anti-Parkinson medication administration. R 5 Carbidopa/Levodopa orders/parameters have been verified w/ the MD. R 5 receives their Carbidopa/Levodopa administered according to MD orders. 2. All other residents receiving Carbidopa/Levodopa have had their orders evaluated to ensure they are receiving medication according to MD orders. 3. Nurses and TMAs have been educated on the 5 rights of medication administration and necessity to follow MD	

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F 755	Continued From page 46 give two tablets by mouth before meals related to Parkinson's Disease. "1 hour prior to MEALS." R5's September Medication Administration Record (MAR) identified the carbidopa-levodopa was scheduled for "AM Pa" (morning medication pass), "Noon," and "PM Pa" (evening medication pass). During a medication pass observation on 9/18/23 at 12:15 p.m., registered nurse (RN)-A reviewed R5's electronic MAR (eMAR) orders, prepared the carbidopa-levodopa for administration, and administered R6 the medication while R5 sat at a dining room table eating her lunch. Immediately following, RN-A was questioned on the administration. She reviewed R5's carbidopa-levodopa order and verbalized the medication should have been administered one hour before she ate. She stated R5 always gets her noon medications with her meals; however, she received her morning carbidopa-levodopa before breakfast when still in her room per her request. A subsequent interview was conducted with RN-A on 9/18/23 at 1:45 p.m. She stated she was expected to follow the five rights of medication administration which included reading the directions and following. She indicated she should have known to give the medication as directed as it was clearly documented in the order when it should have been given; however, she stated she would talk with a manager to adjust the order to better reflect timing of the administration to ensure other staff would not make the same mistake. She was unsure as to why R5 was ordered to have the carbidopa-levodopa one hour	F 755	orders. 10/12/23 4. Audits will be conducted weekly x 8 and then monthly x2 on IDDM Residents to ensure proper administration as it pertains to Carbidopa/Levodopa. Results will be forwarded to the QA/QAPI Committee for further review. Responsible Party: DON/Designee	

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F 755	Continued From page 47 before meals as another resident was scheduled a half hour before meals. Subsequent review of R5's September MAR indicated carbidopa-levodopa was updated to reflect scheduled times for 7:00 a.m., 11:00 a.m., and 4:00 p.m. A medication administration documentation time report was requested related to R5's carbidopa-levodopa; however, none was provided. When interviewed on 9/18/23 at 2:06 p.m., LPN-E stated R5's carbidopa-levodopa was ordered to help her maintain her Parkinson's shaking symptoms. She explained R5 requested her morning dose before she got out of bed so she could have morning symptom control which would help with eating breakfast. During an interview on 9/18/23 at 3:23 p.m., R5 was observed to have upper and lower body movements consistent with Parkinson's Disease. She stated she typically received her morning carbidopa-levodopa right away in the morning before breakfast, the noon dose was normally provided to her during lunch, and her evening dose normally during supper. She stated it varied depending on which nurse was worked. On 9/20/23 at 10:15 a.m. RN-B was interviewed. She expected staff to follow the five rights of medication administration which included ensuring the order directions were followed. If a medication was directed to be provided before meals, she expected the medication to be given prior to meals. If there were concerns related to order directions, she expected staff to	F 755		

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F 755	Continued From page 48 communicate with the provider and/or the pharmacy for clarification. She denied R5 would experience side effects related to being provided her carbidopa-levodopa with meals; however, the medication would be less absorbed and thus less effective and thus this type of error would require a provider update. On 9/22/23 at 9:02 a.m., the nurse for R5's medical provider stated the provider deferred any questions related to carbidopa-levodopa to R5's neurologist. On 9/22/23 at 1:48 p.m., R6's neurologist (MD)-B returned a phone call and left a voice mail which identified ingesting levodopa along with certain foods, such as dietary protein, could decrease the medication absorption into the blood stream and brain, thus decreasing the effectiveness of the medication. Due to this, levodopa was recommended to be scheduled at least one hour before meals. She expected staff to always follow orders related to medication administration. An Administering Medication policy, dated 12/12, identified medications were to be administered in a safe and timely manner, and as prescribed. It directed medications must be administered in accordance with the orders within one hour of their prescribed time, unless otherwise specified i.e., before and after meal orders. The administering staff must check the label "THREE (3) times to verify the right resident ...right dosage, right time ...before giving the medication."	F 755		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		10/16/23

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F 760	Continued From page 49 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications to prevent blood clotting were administered, and associated blood testing was performed, in accordance with physician orders for 1 of 1 residents (R3) reviewed who was at increased risk for recurrent stroke, clots, and/or decreased blood supply to tissues/organs causing a shortage of oxygen, after an ordered blood test was not performed resulting in missed subsequent anticoagulation orders and anticoagulation therapy for a 14 day period. These findings resulted in an immediate jeopardy (IJ) situation, for R3 when the facility failed to take adequate, systemic action(s) to analyze R3's missed blood testing, missed and/or incorrectly administered anticoagulants, failed to update R3's medical provider related to the surrounding anticoagulants and/or blood test concerns, and failed to provide staff education to potential factors which contributed to the error thus causing the potential for similar reoccurrences and potential harm for R3. In addition to the resident in immediate jeopardy, the facility failed to ensure insulin (blood sugar regulator) medication was administered in accordance with physician orders for 1 of 1 residents (R6) who was provided insulin outside of ordered parameters during a medication pass observation. This resulted in potential harm that is not immediate jeopardy. The immediate jeopardy began on 8/28/23, when the facility failed to perform a physician ordered INR (international normalized ratio - blood clotting	F 760	F760 Residents are Free of Significant Medication Errors All residents residing at Glen Oaks have the potential to be affected by the deficient practice. 1. R3 and all residents that are prescribed coumadin orders reconciled and INRs reviewed with next draw dates scheduled. 2. R3 MD notified of coumadin errors, orders reviewed, and no new orders at this time. 3. Medical Director notified of medication errors and current facility regulatory status. 4. Incident reports completed with root cause analysis and review by QAA Committee. 5. Education provided to all licensed nurses and TMAs on the importance of anticoagulation medication administration and INR lab draw order compliance as well as the process for medication administration, provider notification, order processing, and completion for ordered lab draws/communication of results by The Director of Clinical Services (DCS). 6. INR Tracking Log added to facility anticoagulation system with daily audits initiated by nursing leadership team. 7. Nursing leadership team to audit INR tracking log daily to ensure completing of INR and correct orders in place. 8. Audits reviewed daily in morning	

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F 760	Continued From page 50 rate) blood test which led to a lack of subsequently provided anticoagulant order(s). As a result, R3 was not administered anticoagulants from 8/28/23 through 9/10/23. In addition, after the anticoagulation clinic updated the facility on 9/11/23, related to R3's 8/28/23 missed INR and resultant anticoagulant therapy, R3 missed two additional doses on 9/15/23 and 9/17/23, and received one dose higher then ordered on 9/16/23. This resulted in immediate risk of serious harm for R3. The facility administrator, the clinical nurse consultant (NC)-A, and licensed practical nurse (LPN)-E were notified of the immediate jeopardy at 2:26 p.m. on 9/20/23. The immediate jeopardy was removed on 9/21/23 at 12:35 p.m. but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R3's admission Minimum Data Set (MDS), dated 7/21/23, identified R3 was moderately cognitively impaired with a diagnosis of vascular dementia (lack of blood carrying oxygen/nutrients to the brain). In addition, R3 was diagnosed with peripheral vascular disease (abnormal narrowing of arteries), aortic valve stenosis (narrowing), thoracic aortic ectasia (dilation), cerebrovascular disease (impacted blood flow in the brain), hypertension, cardiomyopathy (disease of heart muscles), and intestinal infarct (blocked arteries in intestines. The MDS identified R3 was administered anticoagulant medication for the four days following his facility admission. R3's face sheet listed diagnoses of prior stroke, atherosclerotic heart disease (buildup of plaque in	F 760	Clinical Quality Meeting and results forwarded to the QAA Committee monthly for review. All education completed as part of the facility abatement plan on 9/20/23 Responsible Party: DON/Designee	

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F 760	Continued From page 51 artery walls), and below the knee amputation. A nursing progress note, dated 8/11/23, identified R3's facility tested INR value was 1.4. Results were faxed to the Anticoagulation Clinic (ACC). An Anticoagulation Monitoring Pharmacy Clinic (ACC) progress note, dated 8/11/23, indicated R3's facility tested INR value continued to be "far low of goal range." Goal range of 2.5-3.5 with indicators for anticoagulant use of embolic stroke, aortic valve replacement, and long term (current) use of anticoagulants. The note indicated R3 was at high thrombotic risk due to history of stroke and valve replacement. Due to continued low INR, and prior history of R3 requiring approximately 10 mg (milligrams) weekly dose of warfarin (anticoagulant), the ACC wanted to be "aggressive over the weekend" with dosing and ordered the following: -Start enoxaparin (anticoagulant) 120 mg subcutaneous (SQ) daily (QD). -Warfarin two (2) mg QD on 8/11/23 through 8/13/23. -INR check 8/14/23. -Give morning (am) dose of enoxaparin on 8/14/23 and await warfarin instructions. An ACC progress note, dated 8/14/23, indicated R3's INR value was 2.3 and considered "subtherapeutic." The following orders were provided: -Administer warfarin three (3) mg "today" 8/14/23 and then return to weekly dosing. -Discontinue enoxaparin. -INR check on 8/18/23. R3's August Medication Administration Record (MAR) identified warfarin 3 mg was scheduled	F 760		

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F 760	Continued From page 52 during the evening (pm) shift on 8/14/23; however, the code "9" (other-see progress notes) was charted A nursing progress note, dated 8/14/23 at 9:31 p.m., indicated R3 felt unwell and refused his pm medications; however, took them when offered at bedtime. Once administered, he immediately vomited and his "medication was expelled." He declined to attempt the medications again. In review of R3's record, it was not evident the ACC or physician were notified of the expelled medications or R3 not feeling well. R3's progress note, dated 8/15/23 at 4:16 a.m., identified R3 was sent to the emergency department (ED) for "stroke symptoms" identified as "unable to speak clear, speech mumble[d]/slurred, unable to follow direction, cold, clammy, diaphoretic, unable to grasp or follow finger with eyes." R3's blood pressure was 124/70 and his pulse was 125. 911 was called. A medical provider hospital Summary of Hospitalization note, dated 8/18/23, identified R3's assessment was consistent with recurrent cardiac thromboembolism. R3 was diagnosed new a splenic infarction, multiple acute appearing left-sided cerebral infarctions (strokes), and acute myocardial injury. R3's hospital laboratory report indicated the following hospital INRs: -8/15/23: 2.5. -8/19/23: 3.0. R3's hospital Discharge Summary, dated 8/20/23, indicated he was stable and ready to return to the facility.	F 760		

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F 760	Continued From page 53 An ACC progress note, dated 8/24/23, indicated R3's INR was 2.3 and identified as "near low." The following orders were provided: -Warfarin 2 mg on 8/24/23, 8/25/23, 8/26/23. -Warfarin 1 mg on 8/27/23. No additional warfarin orders were provided past 8/27/23. -INR check on 8/28/23. R3's medical record lacked evidence R3's ordered 8/28/23 INR check was entered into R3's orders for completion and/or completed by facility staff. R3's August and September MARs, date range 8/28/23 through 9/10/23, lacked evidence R3 was administered anticoagulant medication(s). An ACC progress note, dated 9/11/23, indicated the ACC contacted the facility and spoke to licensed practical nurse (LPN)-E to follow up on R3's anticoagulant therapy. The ACC directed the facility to check R3's INR. The INR value was 1.2 (subtherapeutic). The note indicated R3 lacked warfarin administration since 8/27/23. Due to hospitalization in August for splenic infarction, R3 required bridging with enoxaparin until his INR was within 10% of his goal range (2.2). Updated warfarin orders were provided with an INR check ordered for 9/15/23. An ACC progress note, dated 9/15/23, indicated R3's INR was 2.0 and continued to be subtherapeutic (not within his 10% goal range). The following orders were provided: -Enoxaparin 100 mg SQ QD. -Warfarin 2 mg on 9/15/23. -Warfarin 1 mg on 9/16/23 and 9/17/23. -INR check on 9/18/23.	F 760		

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F 760	Continued From page 54 R3's September MAR, date range 9/15/23 through 9/17/23, identified the following: -9/15/23: lack of evidence R3 was provided 2 mg of warfarin as ordered. -9/16/23: R3 was provided 3 mg total of warfarin (2 more mg than ordered) (two separate warfarin orders signed off: one for 1 mg and one for 2 mg). -9/17/23: The enoxaparin was not administered and indicated a chart code of "9" (other-see progress notes). Corresponding nursing notes did not identify why the doses of enoxaparin was not administered. An ACC progress note, dated 9/18/23, indicated R3's INR was 1.4 (subtherapeutic). The note identified the following information: -R3 missed the 9/15/23 warfarin. -R3 was administered 3 mg of warfarin on 9/16/23. -R3 was not administered the 9/17/23 enoxaparin. -Updated warfarin and enoxaparin orders were provided. -INR check on 9/22/23. On 9/18/23, facility medication error reports were requested. One of the reports, dated 9/18/23, indicated R3 missed the 9/15/23 ordered warfarin. The report identified the ACC clinic was updated; however, the report did not include and/or identify an analysis of causal factors that led to the error or corrective action plan to prevent or reduce the risk of future errors. No error reports were provided for the missed doses of anticoagulation on 8/28/23 through 9/10/23, 9/16/23, and 9/17/23.	F 760		

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F 760	Continued From page 55 When interviewed on 9/18/23 at 1:26 p.m., R3 denied medication administration concerns and stated he took Coumadin (warfarin) to thin his blood as his heart did not beat as it should, he suffered a past heart attack, and only was at 30 percent heart pumping capacity. He felt all his INR values were within range and he was provided his medications as ordered. He expected his medications to be administered as ordered and expected the provider to be updated if concerns were identified. On 9/18/23 at 3:56 p.m., the ACC registered nurse (RN)-C was interviewed via telephone and indicated the clinic currently managed R3's anticoagulation therapy in which over the past couple weeks R3's INR readings were "far low ... which indicate[d] no warfarin was given." She explained an INR reading of 0.9 or 1.1 would be an expected value for a person not taking anticoagulant medication. It took approximately five to seven days of missed anticoagulant medication to show a value of 1.1 or lower and then another five to seven days, possibly up to 10 days, to return to the anticoagulation goal range. The only reason an INR reading would value at 1.1 or lower for someone who took anticoagulants was missed medication. The facility was responsible to check the INRs as ordered and update the ACC with the results. RN-C reported the ACC was not updated on 8/28/23 on R3's INR value. ACC staff realized this on 9/11/23 and contacted the facility to inquire. Facility staff denied R3 missed any anticoagulant medication and were unsure as to why the INR was low. RN-C explained R3's low INR values were concerning as R3 had multiple comorbidities and a heart valve which increased his risk for blood clots and associated death.	F 760		

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F 760	Continued From page 56 When interviewed via telephone on 9/19/23, at 2:07 p.m., R3's nurse practitioner (NP)-A stated R3 required daily warfarin due to his blood clotting risk in relation to his blood clotting history and multiple comorbidities. If one dose of warfarin was missed it "would be concerning;" however, would not be a matter of life or death. If 14 days of warfarin were missed, R3 would be at "huge" risk for recurrent stroke, clots, and it "could lead to his death." She stated, after she reviewed R3's clinic chart, the chart lacked information the facility updated her, or the physician, related to R3's medication errors 8/27/23 through 9/10/23, 9/15/23, 9/16/23, and 9/17/23. She explained she expected the facility to update the clinic when medication errors occurred as she and the physician were overall responsible for R3's medical care and may have insight into potential concerns. She reviewed the ACC notes she was able to access and stated she was concerned there appeared to be a lack of facility follow-up to determine why R3's INRs were so subtherapeutic after the ACC clinic updated the facility of their concerns. During an interview on 9/19/23 at 5:49 p.m., LPN-A denied knowledge of anticoagulant concerns with R3 or that staff brought concerns to her while she was in a charge role. In addition, she denied management staff questioned her on any potential concerns related to R3 and she denied recent education related to anticoagulant therapy and/or associated processes was provided to her. When interviewed on 9/19/23 at 6:20 p.m., trained medication aide (TMA)-A denied knowledge of anticoagulant concerns with R3;	F 760		

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F 760	Continued From page 57 however, on 9/15/23 R3's warfarin was not found in the facility, and they awaited it from pharmacy. She explained registered nurse (RN)-B took over around 6:00 p.m., thus, she was unsure if it was administered. She was unsure if she updated RN-B that evening; however, she updated LPN-E before she left. She denied management staff questioned her on any potential concerns related to R3 or that she was provided recent education related to anticoagulant therapy and/or associated processes. A Thrifty White Pharmacy packing slip report, dated 9/15/23, identified four 1 mg warfarin tablets were brought to the facility for R3 which would have covered the 9/15/23 order. During interview on 9/19/23 at 6:43 p.m., management LPN-E explained after an order was initially processed another nurse, typically the night nurse, was expected to double check the order to decrease any potential processing errors. She reviewed R3's anticoagulant therapy orders and the MARs from 8/14/23 through 9/18/23. She stated the 8/28/23 INR lab order was not processed into R3's MAR and thus was not completed as ordered, no anticoagulants were administered from 8/28/23 through 9/10/23 and on 9/15/23, R3 received two more milligrams of warfarin on 9/16/23 than ordered, and enoxaparin was not administered on 9/17/23 as ordered. She was unable to explain the reason the 8/24/23, 9/11/23, and 9/15/23 orders were not double checked by a second nurse. In addition, she was unable to explain the reason for the errors other than processing concerns and a system failure related to the double check process. She was unaware of R3's missed INR lab on 8/28/23 and the missed associated warfarin orders, or of	F 760		

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F 760	Continued From page 58 ACC's communicated concerns; however, she was aware of the three medication errors that started on 9/15/23. She explained the facility had not started an investigation or staff education into any of R3's medication errors and had yet to complete medication error reports for the 9/16/23 and 9/17/23 incidents. LPN-E stated if a medication was missed, the medical provider was expected to be updated. She was unsure if R3's provider was updated; however, she explained being he was followed by the ACC they updated the ACC instead of the provider. In addition, she explained if a resident who required anticoagulation therapy valued an INR around 1.1, that resident was at a very high risk for clots and she would have expected monitoring above and beyond the typical monitoring the facility provided for signs and symptoms of anticoagulant therapy bleeding risk, such as monitoring for blood pooling, extremity pain, and stroke like symptoms. When interviewed on 9/20/23 at 10:15 a.m., RN-B, who was the assistant director of nursing, stated order double checks were an expected part of order processing. This was to be completed "within a day or two" after the order was initially processed and was completed by management or floor nurses if they noticed orders in the double check file. Typically, the night charge nurse completed the double checks; however, that staff member was no longer employed. An INR value of 1.1 for a resident requiring anticoagulant was a concern as that meant the blood was too thick and they were at risk for clotting. She expected the charge nurse to investigate a low INR value as they were responsible for the medications and orders that day. In addition, when INR values were low	F 760		

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F 760	Continued From page 59 and/or subtherapeutic, she expected the charge nurse to contact the ACC and discuss a plan of action. Furthermore, she expected an assessment to be completed if a resident missed anticoagulation medication to ensure resident stability, and to update the medical provider for additional orders, especially since the risk of missed anticoagulation therapy was higher and could increase other medical complications related to clotting. It was not a facility practice to set up missed medication assessment monitoring: "We probably should." When a medication error was identified, staff were expected to complete an incident report by the end of the shift to help rule out any potential concerns, to determine required education if applicable, and to ensure the facility's processes were completed for when errors occurred. RN-B was unaware of the concern severity related to R3's anticoagulation therapy and thus she was unsure as to what occurred or what was investigated/implemented; however, she was aware of his 9/17/23 missed enoxaparin. She explained this error occurred as the medication was not in the facility. She stated staff should have followed the on-call pharmacy processes to request the medication on 9/17/23 instead of waiting until the next day (Monday). In addition, she stated staff should have contacted the ACC or the provider to update for additional instructions as R3 was at a definite risk for clotting and another infarction with possible death. RN-B stated missed anticoagulants were a significant medication error in which R3's anticoagulation medication errors "certainly could have been harm [for R3]." During interview on 9/20/23 at 12:10 p.m., the administrator stated he was not aware of any	F 760		

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F 760	Continued From page 60 systemic medication concerns prior to being updated on R3's anticoagulant and INR concerns after the abbreviated survey started. He expected orders to be processed as directed and was unaware of what nursing did to ensure process accuracy. If an INR value was reported to be low, he expected staff to verify the result and verify the resident was provided the ordered medication(s). In addition, he expected a root cause analysis and for the provider to be updated. He expected the nurse managers (RN-B, LPN-E) to also follow-up and fully investigate any sort of medication and/or order concern. When interviewed via telephone on 9/21/23 at 8:45 a.m., the medical director (MD)-A stated an INR value of 1.1 for an anticoagulated resident would be suspicious as it indicated they were not provided the ordered medication, especially if there were not orders in place to decrease the anticoagulation for procedures or surgery. R3's INR values, missed 8/28/23 INR, and missed/incorrect anticoagulation therapy was discussed. A one-time missed dose would not be a significant concern; however, there was a concern for R3 due to the multiple missed medication and lower INR values. He stated the facility required an order entry process change and expected the facility to be more hypervigilant with warfarin residents. He explained at a minimum a nurse should be in charge every day "for quite a while" to review all warfarin residents to ensure they were provided ordered medication(s) and INRs were completed as ordered. In addition, he expected these residents to be monitored and the provider to at least receive an FYI (for your information) fax to update on anticoagulation concerns such as a missed anticoagulant dose(s).	F 760		

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F 760	Continued From page 61 The immediate jeopardy that began on 8/28/23, was removed on 9/21/23, after the facility reconciled all anticoagulation orders for residents who received warfarin, which included R3, and reviewed INR orders to ensure they were properly scheduled. In addition, R3's provider was updated with no new orders provided. The medical director was updated. Incident reports on identified medication errors were completed with root cause analysis and reviewed by the QAA (quality assurance) committee. Staff education was provided to all licensed nurses and TMAs on the importance of anticoagulation medication administration and INR lab draw order compliance as well as the process for medication administration, provider notification, order processing, and completion of ordered labs draws with communication of results. For staff not in attendance, required recorded education was to be completed before their next working shift. Furthermore, an INR Tracking Log was added to the facility anticoagulation system with daily audits initiated by nursing leadership along with weekly warfarin administration audits. Policy and procedure reviews were conducted with plan for facility QAA committee to review progress of the abatement plan weekly until further notice. Despite this removal plan and actions taken, noncompliance remained at the lower scope and severity level 2 D as the facility failed to ensure insulin (blood sugar regulator) medication was administered in accordance with physician orders for 1 of 1 residents (R6) who was provided insulin outside of ordered parameters during a medication pass observation. _____ _____ _____	F 760		

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F 760	Continued From page 62	F 760		

R6's quarterly MDS, dated 8/10/23, indicated R6 was cognitively intact and was diagnosed with diabetes and utilized insulin seven days a week.

A Endocrinology Diabetes Program progress note, dated 5/30/23, identified R6 was educated on the importance of maintaining good glycemic control due to potential complications of uncontrolled diabetes. R6 was diagnosed with type 2 diabetes mellitus with stage 3 chronic kidney disease and diabetic neuropathy requiring insulin use. The note's Plan section indicated adjusted insulin orders with NovoLog orders directing NovoLog to be given before each of R6's meals.

A NovoLog, NovoLog FlexPen Prescribing Information PDF, dated 2/23, indicated a section labeled Dosage and Administration. This directed administration "within 5 - 10 minutes before a meal ..."

R6's Order Summary Report identified R6 was ordered the following:
-Blood sugar (BS) checks four times a day (QID).
-NovoLog FlexPen 100 unit/ml (milliliters) seven (7) units subcutaneously (SQ) three times a day (TID). Give prior to meals.
-NovoLog FlexPen 100 unit/ml per sliding scale TID (0-149 = 0; 150-200 = 2; 201-251 = -4; 252-302 = 6; 303- 353 = 8; 354-404 = 10; greater than 400 call on call provider.

R6's September Medication Administration Record (MAR) identified the NovoLog was scheduled for 7:30 a.m., 11:30 a.m., and 4:30

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F 760	Continued From page 63 p.m. (half hour prior to mealtimes). During a medication pass observation on 9/18/23 at 12:56 p.m. (one and a half hours after scheduled), LPN-D stated R6's BS check around 11:50 a.m. was 206 and he had yet to receive his lunch time insulin. She reviewed R6's electronic MAR (eMAR) orders and calculated he required 11 units of NovoLog based on his scheduled and sliding scale instructions. She prepped the FlexPen and administered the 11 units of NovoLog insulin to R6. She exited R6's room and documented the administration in the eMAR. Immediately following, LPN-D was interviewed. She stated she provided insulin to residents after they ate as being provided insulin if they did not eat "too good" would "not be good" as their blood sugar could drop too low. LPN-D explained she was expected to read the entire order prior to medication administration and follow the directions as ordered; however, after she reviewed R6's orders, she stated she did not read the entire order as expected and did not follow the administration directions. In addition, she stated she was not aware of the direction to provide the insulin a half hour before meals, and if she had, she would have questioned this direction and would have investigated the order to ensure a transcription error was not made as in her history of nursing it was general nursing practice to administer insulin after meals. She denied there were risks to residents, including R6, if insulin was administered after meals versus prior to as directed. A review of R6's September MAR identified the following scheduled NovoLog insulin administration documented by LPN-D:	F 760		

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F 760	Continued From page 64 -9/5/23 7:30 a.m. dosing: BS 127. Time stamped 9:43 a.m. -9/5/23 11:30 a.m. dosing: BS 189. Time stamped 1:15 p.m. -9/6/23 7:30 a.m. dosing: BS 149. Time stamped 10:07 a.m. -9/13/23 7:30 a.m. dosing: BS 147. Time stamped 9:24 a.m. -9/13/23 11:30 a.m. dosing: BS 152. Time stamped 1:05 p.m. -9/18/23 7:30 a.m. dosing: BS 166. Time stamped 10:15 a.m. -9/18/23 11:30 a.m. dosing: BS 206. Time stamped 1:05 p.m. R6's nursing progress notes, dated 9/5/23 through 9/18/23, lacked rationalization(s) for insulin administration not being provided as ordered i.e., poor intake, illness, R6 preferences and/or refusals prior to meals. On 9/20/23 at 10:15 a.m. RN-B was interviewed. She expected staff to follow the five rights of medication administration which included ensuring the order directions were followed. If a medication was directed to be provided before meals, she expected the medication to be given prior to meals. If there were concerns related to order directions, she expected staff to communicate with the provider and/or the pharmacy for clarification. She would be concerned if R6 was provided his NovoLog after meals as he required this before meals to prevent blood sugar spikes. When interviewed via telephone on 9/21/23 at 8:45 a.m. R6's medical provider MD-A stated the diabetic center managed R6's insulin and he would defer directions to them as they may have	F 760		

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F 760	Continued From page 65 specific reasons why the insulin was scheduled as it was; however, he explained the typical timing of NovoLog would be five to ten minutes before meals. He explained if given prior to meals, a half hour in R6's case, the insulin would have time to peak and cover blood sugars during the meal, thus making the insulin more effective for improved blood sugar control. MD-A was concerned when updated on the medication pass observation as R6's A1C (glycosylated hemoglobin) lab was 8.1 which indicated R6's diabetes was "slightly uncontrolled." On 9/21/23 at 4:40 p.m. the diabetic NP-B was interviewed via telephone. She stated NovoLog rapid acting was typically dosed prior to meals which was a long-standing practice. She explained the general rule was to administer the insulin 15 to 30 minutes prior to meals to decrease pre-meal blood sugars, thus, assisting in blood glucose control maintenance surrounding mealtimes when the blood sugar again would rise. If the insulin was provided after meals, the rising blood sugar acquired during the meal, on top of the blood sugar prior to the meal, would then have to be chased which led to decreased blood glucose control. An Administering Medication policy, dated 12/2012, identified medications were to be administered in a safe and timely manner, and as prescribed. It directed medications must be administered in accordance with the orders within one hour of their prescribed time, unless otherwise specified i.e., before and after meal orders. The administering staff must check the label "THREE (3) times to verify the right resident ...right dosage, right time ...before giving the medication."	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 09/21/2023

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F 760	Continued From page 66 An Adverse Consequences and Medication Errors policy, dated 4/2014, defined a medication error as the preparation or administration of medications which were not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. Examples included, but not limited to, a medication omission, wrong dose, or wrong time. The policy directed that any resident who received any medication with potential for adverse consequence would be monitored to ensure any such consequences were promptly identified and reported and if a medication error was identified the resident would be monitored for possible medication-related adverse consequences. In the event of a significant medication-related error, immediate action was to be taken to protect the resident's safety and welfare. Examples of significant were defined as requiring medication discontinuation or dose modification and/or life threatening. Any significant medication error was to be promptly reported to the attending provider and the error information documented in an incident report and the resident's chart. A Medication Order policy, dated 11/2014, identified the purpose of the policy was to establish uniform guidelines in the receiving and recording of medication orders. The policy lacked information related to any established guidelines for medication and/or procedural order processing. A policy related to order processing was requested. None was provided.	F 760		

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F 760	Continued From page 67 An Anticoagulation - Clinical Protocol policy, dated 11/2018, directed staff and the physician would collaborate in ensuring anticoagulants were assessed for risk, properly prescribed, and monitored for possible complications related to supratherapeutic INR values. The policy lacked information related to ACC collaboration and their role in resident anticoagulation needs. In addition, the policy lacked information related to resident monitoring when subtherapeutic INR values are present.	F 760		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F 865		10/16/23

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F 865	Continued From page 68 §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation	F 865		

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F 865	Continued From page 69 of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 865		

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F 865	Continued From page 70 During a complaint survey exited on 9/21/23, the state survey agency cited deficiencies in the areas of safe functional sanitary/comfortable environment and sufficient nursing staff. While the facility was in substantial compliance on 4/27/23, the Quality Assurance and Performance Improvement (QAPI) program committee was unable to sustain compliance as evidence by the following repeated deficiencies: Findings include: F725- Based on observation, interview and document review the facility failed to provide sufficient nursing staff to meet assessed needs for 5 of 5 residents (R8, R1, R29, R5 and R23) reviewed for activities of daily living (ADLs); quality of care for 1 of 1 (R35) residents reviewed for nursing assessement; 9 of 9 residents (R7, R10, R11, R15, R16, R17, R18, R22 and R25) reviewed for supervision in a memory care unit; RN coverage; and as expressed by Resident Council, Staff, and 2 family members (FM-D and FM-E) who had concerns about the lack of sufficient nursing staff at the nursing home. F921- Based on observation, interview, and document review, the facility failed to fix damaged tile, leaking shower, broken tub in Maple Lane (the only tub that was working in the entire facility). The facility received a citation for this on 3/23/23, and the citation still remains un-fixed. This had the potential to affect all 34 residents who resided in the facility who potentially would use the Maple Lane shower/tub room. During interview on 9/21/23 at 4:00 p.m., administrator stated the facility process improvement plans was in place which included	F 865	F865 QAPI program. The facility does sustain/maintain compliance through the use of the facility QAPI Program. 1. F725 and F921 reviewed by IDT for continued auditing to maintain compliance. 2. QAA Committee to review audits from F725 and F921 and all other cited deficiencies through the facility QAPI Program. 3. Facility leadership team educated on QAPI Policy/Procedures. 10/12/23 4. Campbell Street Services Support Staff to attend QAPI meeting monthly times 3 on site or virtually to ensure continued compliance with the QAPI program requirements and continued follow up of current plan of correction. Responsible Party: ADM/Designee	

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F 865	Continued From page 71 audits on bathing and call light response times in which they saw improvements. In addition, the administrator stated the facility was also working on the tub room but it takes time for the project to be completed adding, they discussed the project at each meeting since the March 2023 survey when cited with the deficiencies and are hoping the project will be finished soon.	F 865		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to fix damaged tile, leaking shower, broken tub in Maple Lane (the only tub that was working in the entire facility). The facility received a citation for this on 3/23/23, and the citation still remains un-fixed. This had the potential to affect all 34 residents who resided in the facility who potentially would use the Maple Lane shower/tub room. Findings include: R19's quarterly minimum data set (MDS) dated 9/22/23, indicated R19 was cognitively intact, required limited assistance with personal hygiene and assist of one with bathing. During interview on 9/13/23 at 5:35 p.m., R19 stated she has not received her shower in the past few days and has not received a bath and it would feel really nice to have a bath if the facility	F 921	F921 Safe/Functional/Sanitary/Comfortable Environment Alleged Compliance Date 10/16/23 F921 Safe/Functional/Sanitary/Comfortable Environment Continued non-compliance with required repairs to shower room on Maple Lane. 1. R19, R5, and R20 are receiving showers as scheduled. Their preferences to have a tub bath have been reviewed and baths will be scheduled when the facility tub is repaired/replaced. Temporary repairs are being done on the existing tub to facilitate baths on a limited basis upon request until the new tub is installed. A new tub has been purchased and will be	10/16/23

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F 921	Continued From page 72 had a bathtub. R5's quarterly MDS dated 7/07/23, indicated R5 was moderately cognitively impaired required extensive assist with ADL's and one person physical assist with bathing. During interview on 9/13/23 at 5:40 p.m., R5 stated she would really enjoy a nice bath, and had not had a bath since she had been at the facility almost two years. R20's annual MDS dated 9/08/23, indicated R20 was cognitively intact required extensive assist of one with personal hygiene and physical assist of one with bathing. During interview on 9/13/23 at 5:51 p.m., R20 stated she would enjoy a tub bath once in awhile if the facility had a tub working in the shower room. During interview and observation on 9/15/23 at 11:49 p.m., the maintenance director (MND) stated the shower head in Maple Lane was observed to be leaking, the MD stated, "the staff just do not know how to shut it off". The MND also stated a construction company from Willmar will be doing the remodel of the tub/shower room but they are a multi-million dollar company and since the project was so small they are not on the "top of their list". The MND stated they do not have a signed contract or any designs made up yet from the company. The MND stated he had called the company and left a message twice and had not received a call back yet but was told a couple of weeks ago they will be doing the project soon.	F 921	delivered on November 17, 2023. Tub room renovations, including the installation of the new tub, are scheduled to be completed no later than November 30, 2023. A collapsible Water Retainer Shower Dam will be installed to prevent the flow of water during showers from running to the shower doorway to the hall to prevent water from running under the door and into the hallway. 2. All residents have the potential to be affected. 3. The Maintenance Director will be re-educated to the Maintenance Service policy, the Supervision, Maintenance Services and Work Order, Maintenance policies (attached) outlining responsibilities and duties of the Maintenance Director. Nursing Home Administrator will monitor the maintenance director□s performance under these policies to ensure that they are being followed as written. 4. The Maintenance Director will conduct audits daily for one (1) week, weekly for one (1) month and monthly for four (4) months to ensure that the old and new tub(s) are working properly, and water is not continuing to run under the shower room door into the hallway. Results will be forwarded to the QAA Committee for review and additional interventions should they be necessary. Alleged Compliance Date 10/16/23	

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F 921	Continued From page 73 During interview on 9/19/23 at 10:35 a.m., administrator stated the facility found the tub they wanted from Apollo, and a contractor from Willmar. In addition, the administrator stated he also had placed a call this week to the Minnesota Department of Health to make sure it was okay to make the renovations to the tub/shower room in Maple Lane and was still waiting for approval. During interview on 9/20/23 at 8:21 p.m., NA-E stated the shower was still leaking in Maple lane and she has almost fallen in the hallway. NA-E further stated they have to shove towels under the door to prevent it from leaking in the hallway. A policy was requested on fixing items and was not provided.	F 921		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 6, 2023

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

Re: State Nursing Home Licensing Orders
Event ID: Y6YB11

Dear Administrator:

The above facility was surveyed on September 11, 2023 through September 21, 2023 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:

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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	00314	A. BUILDING: _____ B. WING _____	C 09/21/2023

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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 9/11/23 through 9/15/23 and 9/18/23 through 9/21/23, 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	2 000		

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2 000	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H53605825C (MN96846); H53605542C (MN96858) with licensing orders issued at 1545; H53605624C (MN96859) with licensing orders issued at 1545; H53605543C (MN96857) with licensing orders issued at 1545; H53605435C (MN96798) with licensing orders issued at 0800 and 0920; H53605348C (MN96634); H53605148C (MN96483) with licensing orders issued at 0800 and (MN96527 and MN96478) with no licensing orders issued; 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	2 000		

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2 000	Continued From page 2 you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility 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		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced	2 255		10/16/23

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2 255	Continued From page 3 by: During a complaint survey exited on 9/21/23, the state survey agency cited deficiencies in the areas of safe functional sanitary/comfortable environment and sufficient nursing staff. While the facility was in substantial compliance on 4/27/23, the Quality Assurance and Performance Improvement (QAPI) program committee was unable to sustain compliance as evidence by the following repeated deficiencies: Findings include: F725- Based on observation, interview and document review the facility failed to provide sufficient nursing staff to meet assessed needs for 5 of 5 residents (R8, R1, R29, R5 and R23) reviewed for activities of daily living (ADLs); quality of care for 1 of 1 (R35) residents reviewed for nursing assessement; 9 of 9 residents (R7, R10, R11, R15, R16, R17, R18, R22 and R25) reviewed for supervision in a memory care unit; RN coverage; and as expressed by Resident Council, Staff, and 2 family members (FM-D and FM-E) who had concerns about the lack of sufficient nursing staff at the nursing home. F921- Based on observation, interview, and document review, the facility failed to fix damaged tile, leaking shower, broken tub in Maple Lane (the only tub that was working in the entire facility). The facility received a citation for this on 3/23/23, and the citation still remains un-fixed. This had the potential to affect all 34 residents who resided in the facility who potentially would use the Maple Lane shower/tub room. During interview on 9/21/23 at 4:00 p.m., administrator stated the facility process improvement plans was in place which included	2 255	Corrected	

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2 255	Continued From page 4 audits on bathing and call light response times in which they saw improvements. In addition, the administrator stated the facility was also working on the tub room but it takes time for the project to be completed adding, they discussed the project at each meeting since the March 2023 survey when cited with the deficiencies and are hoping the project will be finished soon. SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these area on a regular basis and make recommendations for any changes. The administratior will be reponsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by:	2 800		10/16/23

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2 800	Continued From page 5 Based on observation, interview and document review the facility failed to provide sufficient nursing staff to meet assessed needs for 5 of 5 residents (R8, R1, R29, R5 and R23) reviewed for activities of daily living (ADLs); quality of care for 1 of 1 (R35) residents reviewed for nursing assessement; 9 of 9 residents (R7, R10, R11, R15, R16, R17, R18, R22 and R25) reviewed for supervision in a memory care unit; RN coverage; and as expressed by Resident Council, Staff, and 2 family members (FM-D and FM-E) who had concerns about the lack of sufficient nursing staff at the nursing home. Findings include: ASSESSED NEEDS NOT MET: R1's significant change Minimum Data Set (MDS) dated 8/25/23, indicated R1 was moderately cognitively impaired, required extensive assist of two with bed mobility and total assist of two with transfers. The MDS indicated R1 had limited mobility in upper and lower extremity and used a wheelchair for mobility. R1's care plan dated 8/17/23, identified R1 was bariatric had peripheral vascular disease, inflammation of lower extremity, lack of coordination, abnormal posture significant pain management needs and on hospice care. The care plan indicated a two person assist with activity of daily living care and mechanical lift for transfers. A Physical Therapy Treatment Encounter Note indicated an evaluation was completed on 9/13/23, with R1 which indicated "...Physical Therapy recommends a minimum of three staff for Hoyer transfers and that staff move Hoyer lift slowly for resident comfort and safety."	2 800	Corrected	

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2 800	Continued From page 6 During interview on 9/21/23 at 2:35 p.m., TMA-E stated she worked on Sunday 9/17/23, and since there was not enough staff on the day shift they were unable to get R1 out of bed for the day. R8's annual MDS dated 9/08/23, indicated R8 was cognitively intact, needed extensive assist of two with toileting and always incontinent of bowel and bladder. The MDS further indicated she was not on a toileting plan. R8's Care Plan dated 9/08/23, indicated R8 needed assist of one with toileting, provide peri-care with every incontinent episode as necessary. During observation and interview on 9/11/23 at 4:50 p.m. licensed practical nurse (LPN)-B stated R8 was last checked and changed at 1:50 p.m. and on the evening shift they liked to toilet her every two hours or she was usually very wet with urine. LPN-B stated they only have two NAs working on the floor and they are both very busy. LPN-B checked R8 and her pad was saturated in urine and had a pungent odor to it (3 hours after she was last checked). During interview on 9/20/23, at 8:54 p.m. R8's family friend (FF)-A stated she had filed grievances in the past time and time again and promises were made but not kept. FF-A stated there is not enough staff and she finds R8 many times sitting in a full day of feces and urine when she gets there after supper time. MISSED SHOWERS: R1's care plan dated 8/17/23, identified R1 was bariatric and had peripheral vascular disease, inflammation of lower extremity, lack of	2 800		

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2 800	Continued From page 7 coordination, abnormal posture significant pain management needs and on hospice care. The care plan indicated a two person assist with activity of daily living care and mechanical lift for transfers. Review of R1's Bath/Shower sheet indicated on 9/15/23, R1 did not receive a shower and no reason was listed. R29's admission MDS dated 8/29/23, indicated R29 was severely cognitively impaired, required one person physical assist with ADL's and bathing. Review of R29's showers indicated on 9/04/23 and 9/07/23, R29 did not receive shower and no reason was listed. R5's quarterly MDS dated 7/07/23, indicated R5 was moderately cognitively impaired required extensive assist with ADL's and one person physical assist with bathing. Review of R5's showers indicated on 8/27/23, 9/1/23 and 9/15/23, R5 did not receive showers and no reason was listed. R23's significant change MDS dated 9/13/23, indicated R23 was cognitively intact required limited assist with dressing, extensive assist with personal hygiene and two person physical assist with bathing. Review of R23's showers indicated R23 did not receive a shower on 8/11/23 and 9/01/23 and no reason was listed. During interview on 9/11/23 at 3:44 p.m., NA-A stated she was working the evening shift tonight	2 800		

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2 800	Continued From page 8 and they only had myself, a nurse and a TMA working. (confirmed with schedule) NA-A stated they have four scheduled showers tonight that required two assist and there was no way they will be able to complete all four showers. NA-A stated it was not uncommon for the showers to get missed. SEE F677 Quality of Care: R35's significant change Minimum Data Set (MDS) dated 9/01/23, indicated diagnosis of severe cognitive impairment, atrial fibrillation, coronary artery disease, end stage renal disease and hypertension. The MDS indicated R35 required extensive assist of two with dressing, bathing, and grooming. During interview on 9/11/23 at 7:05 p.m., family member (FM)-B stated on 8/25/23, R35 was not acting like himself and was very confused and was normally alert. FM-B stated R35 stated to her that he could not remember where he was at and thought he was back home. FM-B stated her and FM-A knew something was wrong with R35 since he was normally able to identify where he is. FM-B stated she got off of the phone with R35 and called the facility for two hours straight with out getting a hold of anyone, when R35 received his lunch tray R35 told FM-B he did not know what the spoon, knife or fork was for and did not know how to eat. FM-B stated she was finally able to get a hold of licensed practical nurse (LPN)-C and the nurse had no idea what was going on with him and did not appear to know he had cellulitis in his foot. FM-B further stated LPN-C told me he was just a little confusion, and FM-B stated she said it was more than that. During interview on 9/20/23, at 2:00 p.m. LPN-C	2 800		

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2 800	Continued From page 9 stated she was working on 8/25/23 when FM-A called about R35 and stated she was busy that day and there was not enough staff to allow me complete an assessment on R35. SEE F684 MEMORY CARE UNIT DOOR PROPPED OPEN: Supervision During interview on 9/18/23 at 2:00 p.m., LPN-B stated "the weekend was horrible on Saturday 9/16/23, there was only me as the charge nurse, a TMA and a NA scheduled to work. (confirmed with schedule) I received permission from the administrator to prop open the locked memory care unit doors open." LPN-A stated the doors were propped open from 2:00 p.m. until 6:00 p.m. when the activity aide came in and was able to sit with the residents and do activities with them. LPN-B stated luckily none of the residents eloped during that time. LPN-B stated there are nine residents in the unit and many have behaviors and some of them had recent resident to resident physical incidents. LPN-B stated the front door of the building was alarmed if a resident attempted to leave. The following nine residents resided in the memory care unit: R7's quarterly MDS dated 7/27/23, indicated R7 was severely cognitively impaired, had Alzheimer's, dementia, anxiety, and depression. The MDS further indicated R7 had physical behavioral symptoms directed toward others and wandered. R10's significant change MDS dated 9/12/23, indicated R10 had dementia and was severely cognitively impaired, had physical, verbal, and other behavioral symptoms such as hitting toward	2 800		

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2 800	Continued From page 10 others or scratching and pacing. The MDS indicated rejection of care and wandering. R11's quarterly MDS dated 9/20/23, indicated R11 was moderately cognitively impaired and had fractures and other multiple trauma. The MDS further indicated R11 had physical behaviors of hitting kicking towards others, rejection of care and wandering. R15's quarterly MDS dated 8/03/23, indicated R15 was cognitively intact and had progressive neurological conditions, Alzheimer's, and dementia. The MDS also indicated R15 had verbal behaviors. R16's quarterly MDS dated 9/15/23, indicated R16 was moderately cognitively impaired and had dementia and schizophrenia. The MDS also indicated R16 had physical and verbal behaviors, rejects care and wanders. R17's quarterly MDS dated 9/15/23, indicated R17 was severely cognitively impaired and had dementia and non-traumatic brain dysfunction. The MDS further indicated R17 had physical behaviors and wandered. R18's quarterly MDS dated 8/26/23, indicated R18 was severely cognitively impaired, had Alzheimer's disease. The MDS further indicated R18 wandered. R22's quarterly MDS dated 9/01/23, indicated R22 was severely cognitively impaired, had Alzheimer's and dementia. The MDS indicated R22 would reject care. R25's quarterly MDS dated 9/15/23, indicated R25 was severely cognitively impaired, had	2 800		

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2 800	Continued From page 11 non-traumatic brain dysfunction and dementia. The MDS further indicated R25 would reject care. RN Coverage: On 9/09/23 and 9/10/23, the facility had no RN coverage for both days. Interview on 9/11/23 at 2:00 p.m., the director of nursing (DON) stated she was not aware there was no RN coverage over the weekend but that was probably correct. During interview on 9/12/23 at 3:00 p.m., the human resource director and admissions assistant stated the staffing coordinator has been on a leave of absence and they have been in charge of the scheduling and did not realize they had no RN coverage over the past weekend. Although the RN on-call should have covered those hours. SEE F727 RESIDENT COUNCIL: Review of resident council meeting minutes for the last three months indicated the following: 7/06/2023 New Concerns with staffing: -Have to wait to go to the bathroom so long that it becomes to late -EZ stand is not available to go to the bathroom and never returned -resident left in the dinning room for an hour -Call light left on for 1 hour and 15 minutes 8/03/2023 Follow up to concerns from 7/06/23: -Have to wait to go to the bathroom so long that it becomes to late (still an issue 8/03/23) -EZ stand is not available to go to the bathroom	2 800		

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2 800	Continued From page 12 and never return (still an issue 8/03/23) -Left in the dinning room for an hour (still an issue 8/03/23) -Call light left on for 1 hour and 15 minutes (call lights still an issue 8/03/23) New Concerns with staffing: -Room trays delivered 30 to 40 minutes late -Not enough staffing and staff working tell the residents they are short 9/12/23 Follow up to concerns from 7/06/23: -Have to wait to go to the bathroom so long that it becomes to late (still an issue 9/12/23) -EZ stand is not available to go to the bathroom and never return (not mentioned) -Left in the dinning room for an hour (still an issue 9/12/23, but improving) -Call light left on for 1 hour and 15 minutes (call lights still an issue 9/12/23) Follow up to concerns from 8/03/23: -Room trays delivered 30 to 40 minutes late (not mentioned) -Not enough staffing and staff working tell the residents they are short (still an issue 9/12/23) New Concerns with staffing: -Call lights turned off and aides tell them will be back in 2 minutes and return 20 minutes later STAFF CONCERNS: During interview on 9/11/23 at 2:35 p.m., LPN-B stated she works the evening shift as the charge nurse and was the only licensed staff in the building for 34 residents. LPN-B stated she was responsible for passing medications, taking phone calls and assisting the aides on the floor. In addition LPN-B stated nurse management was	2 800		

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2 800	Continued From page 13 never available on the weekends when they are on-call and they have no support from them. In addition, LPN-B stated showers are not getting completed like they should be and family members are getting angry with staff because cares are not getting done. LPN-B stated she has reported all of this to management and nothing seems to get done to make it better. During interview on 9/18/23 at 4:06 p.m., NA-A stated she had told management the residents need better care, here and last night baths were not done and we get yelled at that our work is not done. NA-A stated yesterday evening the residents also had to eat in their rooms because there was not enough staff to bring them down to the dining room and several of them were upset. During interview on 9/18/23 at 7:25 p.m., LPN-C stated the staffing was terrible over the weekend and on Sunday 9/17/23, LPN-C stated she was the only nurse in the building and was told R10 hit another resident in the face by the trained medical assistant TMA-B. LPN-C stated she was so busy giving insulin's that morning she was unable to assist with the incident and did not have time to do any charting on it. FAMILY CONCERNS: During interview on 9/19/23 at 4:01 p.m., FM-D stated he visits R12 three times a day and does not feel there is adequate staffing at the facility. FM-D stated last weekend there was not enough staff and R12 had to eat supper in her room and again last night. FM-D stated every morning when he comes to visit R12 she was always waiting in the doorway of her room to use the bathroom and when they put her on the toilet she often has to wait over 30 minutes to be taken off. FM-D stated he goes home in a bad mood and sometimes he	2 800		

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2 800	Continued From page 14 sheds tears over it and stated, sometimes I wonder when the staff go home at night if they worry too?" FM-D stated the staff do work very hard, they just don't have enough of them. During interview on 9/20/23 at 11:00 a.m., FM-E stated he visits R4 and in the evening many times when R4 had to go to the bathroom and when her call light was put on it could take staff 30 to 45 minutes to answer the call light and that was too long, R4 could not wait that long. FM-E stated he does not think the staff does that on purpose there just was just not enough staff to help. In addition, FM-E stated twice last week R4 had to eat supper in her room because they did not have enough staff. FM-E further stated he was impressed with the staff they have, adding they are very good. During interview on 9/13/23 at 12:14 p.m., DON stated the facility had adequate staffing and according to corporate, they have the largest amount of staff hours compared to other buildings. The DON stated the facility can staff with one nursing assistant to 10 residents. During interview on 9/19/23 at 1:20 p.m., administrator stated the staffing was not ideal and they try to come in to provide support to the staff. The administrator further stated it was possible they don't always have RN coverage and they attempt to use supplemental nursing staff from agencies but they are often not able to help. The administrator stated he did allow the memory care door to be propped open when there was not enough staff but only to make sure staff had supervision on all of the memory care residents at all times. The administrator also stated he was aware they were having difficulties with the on-call nurse coming in on the weekends during staffing	2 800		

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2 800	Continued From page 15 issues and one of there RN's just put in her resignation and the other one has been on maternity leave but will be coming back in October. Administrator further stated they just hired a new LPN and they are constantly running adds for help. Facility Staffing Policy revised October 2017, indicated "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plan." In addition the policy indicated staffing numbers and skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. Inquires or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee should ensure adequate policy and programs are developed for sufficient staffing based on the resident population to staffing availability so residents received safe, adequate and timely assistance with toileting, bathing, transfers, supervision, assessments and overall quality of care. The facility should educate staff on these policies and perform audits of resident care to ensure residents are receiving care and services with adequate staffing. The facility should report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		

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	00314	A. BUILDING: _____ B. WING _____	C 09/21/2023

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2 810	Continued From page 16	2 810		
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours a day for a weekend when there was no RN scheduled. Findings include: Review of the facility schedule identified no RN coverage as follows: On 9/09/23 and 9/10/23, the facility had no RN coverage for both days. Interview on 9/11/23 at 2:00 p.m., the director of nursing (DON) stated she was not aware there was no RN coverage over the weekend but that was probably correct. During interview on 9/12/23 at 3:00 p.m., the human resource director and admissions assistant stated the staffing coordinator has been on a leave of absence and they have been in charge of the scheduling and did not realize they had no RN coverage over the past weekend. Although the RN on-call should have covered those hours. During interview on 9/12/23 at 4:00 p.m., licensed practical nurse (LPN)-B stated she called the RN	2 810	Corrected	10/16/23

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2 810	Continued From page 17 on-call and no one answered the phone until finally LPN- E answered and was unable to come in, eventhough she was not even a RN. LPN-B stated it was not uncommon for the on-call RN not to answer or common in to assist with staffing issues at the facility. Facility policy Nurse Manager on Call dated 1/10/23, indicated "The 4 Nurse Managers consist of Director of Nursing, the Assistant Directors of Nursing, and the Clinical Day Supervisor". Nurse Managers will be on an "On-Call" rotation schedule consisting of 1 week in every four weeks, including weekends- Monday to Monday. The responsibility to being on-call includes the potential of providing emergency coverage inside the facility in the event of a staffing need, on the designated weekend of being on-call. In addition the policy indicated not responding to the on-call needs can lead to disciplinary action, as lack of response can potentially impact the safety and well-being of residents and staff. The policy had signatures of the DON, ADON-A, ADON-B and Clinical day supervisor (LPN)-E. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop policies and procedures to ensure nursing coverage is provided 8 hours per day, 7 days per week. The DON or designee could educate staff regarding these polices, and audit staff schedules for compliance. The DON or designee could take the results of these audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 810		

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2 830	Continued From page 18	2 830		
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 investigate and respond to a Hoyer lift incident before placing the Hoyer lift back into care service for 1 of 2 (R2) residents. Additionally, the facility failed to have a system to perform regular maintenance on resident ceiling lift and failed to respond to voiced concerns by nursing staff related to ceiling lift malfunction and safety related to care planned two person Hoyer lift for 1 of 2 (R1) resident viewed for accidents. This resulted in an immediate jeopardy (IJ) situation for R2 and R1. The IJ began on 7/30/23 at 8:22 a.m., when a Hoyer lift being used to transfer R2 would "not stop" and a different Hoyer lift had to be used to complete the transfer. The Hoyer lift was placed out of service for a short period but returned to service before the facility completed an internal	2 830	Corrected	10/16/23

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2 830	Continued From page 19 investigation or contacted the manufacturer for direction. Additionally, the facility failed to have a system for routine maintenance related to a ceiling lift used to transfer R1 which had ongoing staff reports of malfunction over the last six months and failed to reassess R1's safe transfer in a Hoyer lift, both potentially causing R1 discomfort and pain. The DON and administrator were notified of the IJ on 9/14/23, at 5:35 p.m. The IJ was removed on 9/15/23, at 5:35 p.m. but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: R2's annual MDS dated 8/23/23, indicated R2 was cognitively intact, required extensive assist of two with bed mobility, transfers, impairment on upper extremities and used a wheelchair for mobility. R2's Care Plan dated 8/29/23, indicated R2 had spinal Stenosis (narrowing of the spinal canal in the lower part of back), osteoporosis, edema, and lower back pain. Care plan further indicated R2 transferred with assist of two and mechanical lift. 9/12/23-9/15/23, R1 was in the hospital and unable to be observed or interviewed. Incident Report dated 7/30/23 at 8:22 a.m., indicated R2 was being transferred by two staff and Hoyer lift out of bed. Resident was being lowered down and Hoyer lift would not stop. R2 ended up sitting in sling about a foot off the ground; the Hoyer would "not stop" when stop button was pushed, needed another Hoyer to complete transfer. The report indicated staff	2 830		

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2 830	Continued From page 20 assisted resident with another Hoyer lift and four staff to place resident in her wheelchair. Hoyer machine was taken off the floor and a repair slip completed for maintenance. Report indicated no injuries occurred to R2. During interview on 9/13/23 at 7:00 p.m., NA- B stated on 7/30/23, she was transferring R2 with the Hoyer lift out of bed when the lift automatically just started to lower to the ground, NA-B stated R2 had jerking movements with her body and maybe that caused the lift to lower on its own. NA-B also stated with R1 they have had issues with the ceiling lift battery not charging and she had told the MND several times and he just told us to make sure we have the battery on the charger correctly. NA-B stated we tried that, and it doesn't charge the battery. During interview on 9/14/23 at 8:07 a.m., MND stated he was aware of the incident with R2 and looked over the Hoyer lift but was unable to find anything wrong with the lift, so he put the lift back on the floor for staff to use. The MND confirmed he never called the manufacturer to see if it was safe to put back on the floor despite the manufacturer primarily working with the lifts, completing the maintenance on a routine basis and all the lifts having just been checked two weeks prior to the incident. The MND did state he had never called the manufacture for a concern since they come out every 6 months to do their safety checks and maintenance on them. During interview on 9/14/23 at 8:30 a.m., director of nursing (DON) stated she was aware of the incident with R2 and the lift lowering R2 to the floor. DON added, since MND looked at the lift and was unable to find anything wrong, she felt there was no reason to complete an investigation	2 830		

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2 830	Continued From page 21 on the incident. During interview on 9/14/23 at 9:14 a.m., EZ Way Service and Sales Support staff stated the EZ Way Hoyer lift should have been removed from the floor and not been put back onto the floor until calling EZ Way, due to the possibility of brake failure of the machine and needing to complete two checks over the phone and if that did not work a technician might need to come out to look over the machine. During interview on 9/14/23 at 10:00 a.m. EZ Way representative (R)-A stated the facility had preventive maintenance done on the EZ Way lifts and stands on 9/20/22 and then on 7/17/23 and 7/18/23. The R-A stated the facility should have had preventative maintenance done in March 2023 but was not scheduled. EZ Way, INC. Service Manual revised 7/11/22, indicated the manufacturer suggests that the following components and operating points be scheduled for inspection at intervals not greater than six months. Any detected deficiency must be rectified before the lift is put back into service. R1's significant change Minimum Data Set (MDS) dated 8/25/23, indicated R1 was moderately cognitively impaired, required extensive assist of two with bed mobility and total assist of two with transfers. The MDS indicated R1 had limited mobility in upper and lower extremity and used a wheelchair for mobility. R1's care plan dated 8/17/23, identified R1 was bariatric and had peripheral vascular disease, inflammation of lower extremity, lack of coordination, abnormal posture, significant pain management needs and was on hospice care.	2 830		

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2 830	Continued From page 22 The care plan indicated a two person assist with activity of daily living care and mechanical lift for transfers. On 9/12/23 at 12:43 p.m., during observation and interview R1 was observed being transferred from wheelchair to bed using a ceiling lift by nursing assistant (NA)-C, NA-D and trained medical aide (TMA)-B. R1 was several inches off her wheelchair when the ceiling lift stopped, staff were observed working with the remote to get the lift working. R1 was observed to be jerked up and down by the lift during this time and yelling out, "ouch" and was crying. Staff stopped and put her back in chair. Staff reported they told leadership the ceiling lift was not working, "again." Per interviews with (NA)-C, NA-D and (TMA)-B the ceiling lift had not been functioning correctly for over six months. Staff expressed they believed R1 preferred the ceiling lift, and it was safer and more comfortable for her to use than the EZ Way Hoyer Lift. The staff stated when they have used the Hoyer lift in the past some of them have had to stand on the legs of the lift to prevent it from tipping over. Additional concerns the staff expressed included the ceiling lift stopping and jerking R1, causing her unnecessary pain during transfers. They expressed this was something that had been ongoing despite complaints they had made to leadership and requests for repairs to maintenance. When they put maintenance request in, MND would instruct them to put the battery on the charger tilted or crooked to get it to charge, which was not a sustainable solution. During same observation surveyor attempted to interview R1 but she was not interviewable. A second observation and interview on 9/12/23 at 1:10 p.m., during transfer from the wheelchair to her bed using the EZ Way Hoyer Lift. The MND	2 830		

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2 830	Continued From page 23 was asked by facility leadership to demonstrate how to use the EZ Way Hoyer Lift safely with R1. MND and NA-C, NA-D and TMA-B were observed hooking R1 up to the EZ Way Hoyer Lift from her wheelchair, bed was in low position, MND was running the EZ Way Hoyer Lift while the aids were guiding R1. When R1 was in the air, the EZ Way Hoyer Lift wheel was observed to lift off the ground two inches and the transfer had to be halted due to the bed being in the wrong placement position for transfer (bed in low position), which caused R1 to yell out in pain. Interview with DON confirmed the transfer with R1 was not completed the way she would have transferred R1. According to manufacturer during an interview on 9/14/23 at 3:30 p.m., the EZ Way Hoyer Lift is not safe or stable to use if the wheels are not all on the ground during transfers and if the wheels are lifting off the ground, this could be because of a bent frame or broken bolt(s). After observation of resident transfer on 9/12/23, at 1:10 p.m. Hoyer was not removed from resident care and staff were not immediately retrained. A Physical Therapy Treatment Encounter Note indicated an evaluation was completed on 9/13/23 with R1 which indicated, "...Physical Therapy recommends a minimum of three staff for Hoyer transfers and that staff move Hoyer lift slowly for resident comfort and safety." During interview on 9/13/23 at 11:52 a.m., DON stated the MND does the training with the staff on the Hoyer lifts and assumed he received training from the EZ Way. The DON stated the MND was not a NA or trained in patient care and should not	2 830		

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2 830	Continued From page 24 have had him transfer R1. During interview on 9/13/23 at 2:34 p.m., MND stated he encouraged staff to scan the QR code on the lifts and watch the video for training on the lifts. The MND stated he had not received training from EZ Way to transfer residents in the Hoyer lifts. During interview on 9/15/23 at 9:00 a.m., MND stated the ceiling lifts were purchased from Direct Supply company but he was told by corporate they were no longer working with Direct Supply for the ceiling lift (for approximately a year and a half) so he was not able to purchase replacement batteries for the lift. MND stated he was not aware of any contracted routine maintenance for the ceiling lift and confirmed he had not completed any routine maintenance on the lift himself but had directed staff to put the battery on the charger different ways to get it to charge better. During interview 9/20/23 at 6:20 p.m., the facility nurse consultant stated she had been the consultant with the facility for the past year and was not aware the ceiling lift was being used for resident care. The IJ that started on 7/30/23 was removed on 9/15/23, when it was verified through observation, interview and document review the facility removed the Hoyer lift and ceiling lift from resident care pending inspection/routine maintenance check, retrained staff on safe transfers with the EZ Way Hoyer lifts and reviewed policies and procedures to ensure alignment with regulatory standards. All staff were educated on the procedures.	2 830		

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2 830	Continued From page 25 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely incontinence care for 1 of 1 residents (R8) and bathing as care planned for 4 of 4 residents (R1, R29, R5 and R23) who were dependent upon staff for assistance with activities of daily living (ADL). Findings include: R8's annual MDS dated 9/08/23, indicated R8	2 920	Corrected	10/16/23

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2 920	Continued From page 26 was cognitively intact, needed extensive assist of two with toileting and always incontinent of bowel and bladder. The MDS further indicated she was not on a toileting plan. R8's Care Plan dated 9/08/23, indicated R8 needed assist of one with toileting, provide peri-care with every incontinent episode as necessary. During observation and interview on 9/11/23 at 4:50 p.m., licensed practical nurse (LPN)-B stated R8 was last checked and changed at 1:50 p.m. and on the evening shift they like to toilet her every two hours or she was usually very wet with urine. LPN-B stated they only have two nursing assistants (NA) working on the floor and they are both very busy. LPN-B checked R8 and her pad was saturated in urine and had a pungent odor (3 hours after she was last checked). During interview on 9/20/23, at 8:54 p.m. R8's family friend (FF)-A stated they had filed grievances in the past time and time again and promises are made but not kept. FF-A stated there was not enough staff and she finds R8 many times sitting in a full day of feces and urine when she gets there after supper. R1's significant change Minimum Data Set (MDS) dated 8/25/23, indicated R1 was moderately cognitively impaired, required extensive assist of two with bed mobility and total assist of two with transfers. The MDS indicated R1 had limited mobility in upper and lower extremity and used a wheelchair for mobility. R1's care plan dated 8/17/23, identified R1 was bariatric and had peripheral vascular disease, inflammation of lower extremity, lack of	2 920		

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2 920	Continued From page 27 coordination, abnormal posture significant pain management needs and on hospice care. The care plan indicated a two person assist with activity of daily living care and mechanical lift for transfers. Review of R1's Bath/Shower sheet indicated on 9/15/23, R1 did not receive a shower and no reason was listed. R29's admission MDS dated 8/29/23, indicated R29 was severely cognitively impaired, required one person physical assist with ADL's and bathing. Review of R29's showers indicated on 9/04/23 and 9/07/23, R29 did not receive shower and no reason was listed. R5's quarterly MDS dated 7/07/23, indicated R5 was moderately cognitively impaired required extensive assist with ADL's and one person physical assist with bathing. Review of R5's showers indicated on 8/27/23, 9/1/23 and 9/15/23, R5 did not receive showers and no reason was listed. R23's significant change MDS dated 9/13/23, indicated R23 was cognitively intact required limited assist with dressing, extensive assist with personal hygiene and two person physical assist with bathing. Review of R23's showers indicated R23 did not receive a shower on 8/11/23 and 9/01/23 and no reason was listed. During interview on 9/11/23 at 3:44 p.m. NA-A stated she was working the evening shift tonight	2 920		

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2 920	Continued From page 28 and right now they only have myself, a nurse and a TMA working. NA-A stated they have four scheduled showers tonight that require two assist and there was no way she will be able to complete all of the showers scheduled. NA-A stated it was not uncommon for the showers to get missed or not completed when there was not enough help on the floor (two NA's). During interview on 9/12/23 at 11:00 a.m. director of nursing (DON) stated the showers should be completed and missed showers should be made up the follow day. The DON further stated she had been doing audits on the showers and thought they were getting done. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:	21545		10/16/23

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21545	Continued From page 29 (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications to prevent	21545	Corrected	

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21545	Continued From page 30 blood clotting were administered, and associated blood testing was performed, in accordance with physician orders for 1 of 1 residents (R3) reviewed who was at increased risk for recurrent stroke, clots, and/or decreased blood supply to tissues/organs causing a shortage of oxygen, after an ordered blood test was not performed resulting in missed subsequent anticoagulation orders and anticoagulation therapy for a 14 day period. These findings resulted in an immediate jeopardy (IJ) situation, for R3 when the facility failed to take adequate, systemic action(s) to analyze R3's missed blood testing, missed and/or incorrectly administered anticoagulants, failed to update R3's medical provider related to the surrounding anticoagulants and/or blood test concerns, and failed to provide staff education to potential factors which contributed to the error thus causing the potential for similar reoccurrences and potential harm for R3. In addition to the resident in immediate jeopardy, the facility failed to ensure insulin (blood sugar regulator) medication was administered in accordance with physician orders for 1 of 1 residents (R6) who was provided insulin outside of ordered parameters during a medication pass observation. This resulted in potential harm that is not immediate jeopardy. The immediate jeopardy began on 8/28/23, when the facility failed to perform a physician ordered INR (international normalized ratio - blood clotting rate) blood test which led to a lack of subsequently provided anticoagulant order(s). As a result, R3 was not administered anticoagulants from 8/28/23 through 9/10/23. In addition, after the anticoagulation clinic updated the facility on 9/11/23, related to R3's 8/28/23 missed INR and resultant anticoagulant therapy, R3 missed two additional doses on 9/15/23 and 9/17/23, and	21545		

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21545	Continued From page 31 received one dose higher then ordered on 9/16/23. This resulted in immediate risk of serious harm for R3. The facility administrator, the clinical nurse consultant (NC)-A, and licensed practical nurse (LPN)-E were notified of the immediate jeopardy at 2:26 p.m. on 9/20/23. The immediate jeopardy was removed on 9/21/23 after the facility implemented a removal plan; however, non-compliance remained at the lower scope and severity level 2 D scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R3's admission Minimum Data Set (MDS), dated 7/21/23, identified R3 was moderately cognitively impaired with a diagnosis of vascular dementia (lack of blood carrying oxygen/nutrients to the brain). In addition, R3 was diagnosed with peripheral vascular disease (abnormal narrowing of arteries), aortic valve stenosis (narrowing), thoracic aortic ectasia (dilation), cerebrovascular disease (impacted blood flow in the brain), hypertension, cardiomyopathy (disease of heart muscles), and intestinal infarct (blocked arteries in intestines. The MDS identified R3 was administered anticoagulant medication for the four days following his facility admission. R3's face sheet listed diagnoses of prior stroke, atherosclerotic heart disease (buildup of plaque in artery walls), and below the knee amputation. A nursing progress note, dated 8/11/23, identified R3's facility tested INR value was 1.4. Results were faxed to the Anticoagulation Clinic (ACC). An Anticoagulation Monitoring Pharmacy Clinic	21545		

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21545	Continued From page 32 (ACC) progress note, dated 8/11/23, indicated R3's facility tested INR value continued to be "far low of goal range." Goal range of 2.5-3.5 with indicators for anticoagulant use of embolic stroke, aortic valve replacement, and long term (current) use of anticoagulants. The note indicated R3 was at high thrombotic risk due to history of stroke and valve replacement. Due to continued low INR, and prior history of R3 requiring approximately 10 mg (milligrams) weekly dose of warfarin (anticoagulant), the ACC wanted to be "aggressive over the weekend" with dosing and ordered the following: -Start enoxaparin (anticoagulant) 120 mg subcutaneous (SQ) daily (QD). -Warfarin two (2) mg QD on 8/11/23 through 8/13/23. -INR check 8/14/23. -Give morning (am) dose of enoxaparin on 8/14/23 and await warfarin instructions. An ACC progress note, dated 8/14/23, indicated R3's INR value was 2.3 and considered "subtherapeutic." The following orders were provided: -Administer warfarin three (3) mg "today" 8/14/23 and then return to weekly dosing. -Discontinue enoxaparin. -INR check on 8/18/23. R3's August Medication Administration Record (MAR) identified warfarin 3 mg was scheduled during the evening (pm) shift on 8/14/23; however, the code "9" (other-see progress notes) was charted A nursing progress note, dated 8/14/23 at 9:31 p.m., indicated R3 felt unwell and refused his pm medications; however, took them when offered at bedtime. Once administered, he immediately	21545		

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21545	Continued From page 33 vomited and his "medication was expelled." He declined to attempt the medications again. In review of R3's record, it was not evident the ACC or physician were notified of the expelled medications or R3 not feeling well. R3's progress note, dated 8/15/23 at 4:16 a.m., identified R3 was sent to the emergency department (ED) for "stroke symptoms" identified as "unable to speak clear, speech mumble[d]/slurred, unable to follow direction, cold, clammy, diaphoretic, unable to grasp or follow finger with eyes." R3's blood pressure was 124/70 and his pulse was 125. 911 was called. A medical provider hospital Summary of Hospitalization note, dated 8/18/23, identified R3's assessment was consistent with recurrent cardiac thromboembolism. R3 was diagnosed new a splenic infarction, multiple acute appearing left-sided cerebral infarctions (strokes), and acute myocardial injury. R3's hospital laboratory report indicated the following hospital INRs: -8/15/23: 2.5. -8/19/23: 3.0. R3's hospital Discharge Summary, dated 8/20/23, indicated he was stable and ready to return to the facility. An ACC progress note, dated 8/24/23, indicated R3's INR was 2.3 and identified as "near low." The following orders were provided: -Warfarin 2 mg on 8/24/23, 8/25/23, 8/26/23. -Warfarin 1 mg on 8/27/23. No additional warfarin orders were provided past 8/27/23. -INR check on 8/28/23.	21545		

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21545	Continued From page 34 R3's medical record lacked evidence R3's ordered 8/28/23 INR check was entered into R3's orders for completion and/or completed by facility staff. R3's August and September MARs, date range 8/28/23 through 9/10/23, lacked evidence R3 was administered anticoagulant medication(s). An ACC progress note, dated 9/11/23, indicated the ACC contacted the facility and spoke to licensed practical nurse (LPN)-E to follow up on R3's anticoagulant therapy. The ACC directed the facility to check R3's INR. The INR value was 1.2 (subtherapeutic). The note indicated R3 lacked warfarin administration since 8/27/23. Due to hospitalization in August for splenic infarction, R3 required bridging with enoxaparin until his INR was within 10% of his goal range (2.2). Updated warfarin orders were provided with an INR check ordered for 9/15/23. An ACC progress note, dated 9/15/23, indicated R3's INR was 2.0 and continued to be subtherapeutic (not within his 10% goal range). The following orders were provided: -Enoxaparin 100 mg SQ QD. -Warfarin 2 mg on 9/15/23. -Warfarin 1 mg on 9/16/23 and 9/17/23. -INR check on 9/18/23. R3's September MAR, date range 9/15/23 through 9/17/23, identified the following: -9/15/23: lack of evidence R3 was provided 2 mg of warfarin as ordered. -9/16/23: R3 was provided 3 mg total of warfarin (2 more mg than ordered) (two separate warfarin orders signed off: one for 1 mg and one for 2 mg). -9/17/23: The enoxaparin was not administered	21545		

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21545	Continued From page 35 and indicated a chart code of "9" (other-see progress notes). Corresponding nursing notes did not identify why the doses of enoxaparin was not administered. An ACC progress note, dated 9/18/23, indicated R3's INR was 1.4 (subtherapeutic). The note identified the following information: -R3 missed the 9/15/23 warfarin. -R3 was administered 3 mg of warfarin on 9/16/23. -R3 was not administered the 9/17/23 enoxaparin. -Updated warfarin and enoxaparin orders were provided. -INR check on 9/22/23. On 9/18/23, facility medication error reports were requested. One of the reports, dated 9/18/23, indicated R3 missed the 9/15/23 ordered warfarin. The report identified the ACC clinic was updated; however, the report did not include and/or identify an analysis of causal factors that led to the error or corrective action plan to prevent or reduce the risk of future errors. No error reports were provided for the missed doses of anticoagulation on 8/28/23 through 9/10/23, 9/16/23, and 9/17/23. When interviewed on 9/18/23 at 1:26 p.m., R3 denied medication administration concerns and stated he took Coumadin (warfarin) to thin his blood as his heart did not beat as it should, he suffered a past heart attack, and only was at 30 percent heart pumping capacity. He felt all his INR values were within range and he was provided his medications as ordered. He expected his medications to be administered as ordered and expected the provider to be updated if concerns were identified.	21545		

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21545	Continued From page 36 On 9/18/23 at 3:56 p.m., the ACC registered nurse (RN)-C was interviewed via telephone and indicated the clinic currently managed R3's anticoagulation therapy in which over the past couple weeks R3's INR readings were "far low ... which indicate[d] no warfarin was given." She explained an INR reading of 0.9 or 1.1 would be an expected value for a person not taking anticoagulant medication. It took approximately five to seven days of missed anticoagulant medication to show a value of 1.1 or lower and then another five to seven days, possibly up to 10 days, to return to the anticoagulation goal range. The only reason an INR reading would value at 1.1 or lower for someone who took anticoagulants was missed medication. The facility was responsible to check the INRs as ordered and update the ACC with the results. RN-C reported the ACC was not updated on 8/28/23 on R3's INR value. ACC staff realized this on 9/11/23 and contacted the facility to inquire. Facility staff denied R3 missed any anticoagulant medication and were unsure as to why the INR was low. RN-C explained R3's low INR values were concerning as R3 had multiple comorbidities and a heart valve which increased his risk for blood clots and associated death. When interviewed via telephone on 9/19/23, at 2:07 p.m., R3's nurse practitioner (NP)-A stated R3 required daily warfarin due to his blood clotting risk in relation to his blood clotting history and multiple comorbidities. If one dose of warfarin was missed it "would be concerning;" however, would not be a matter of life or death. If 14 days of warfarin were missed, R3 would be at "huge" risk for recurrent stroke, clots, and it "could lead to his death." She stated, after she reviewed R3's clinic chart, the chart lacked information the	21545		

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21545	Continued From page 37 facility updated her, or the physician, related to R3's medication errors 8/27/23 through 9/10/23, 9/15/23, 9/16/23, and 9/17/23. She explained she expected the facility to update the clinic when medication errors occurred as she and the physician were overall responsible for R3's medical care and may have insight into potential concerns. She reviewed the ACC notes she was able to access and stated she was concerned there appeared to be a lack of facility follow-up to determine why R3's INRs were so subtherapeutic after the ACC clinic updated the facility of their concerns. During an interview on 9/19/23 at 5:49 p.m., LPN-A denied knowledge of anticoagulant concerns with R3 or that staff brought concerns to her while she was in a charge role. In addition, she denied management staff questioned her on any potential concerns related to R3 and she denied recent education related to anticoagulant therapy and/or associated processes was provided to her. When interviewed on 9/19/23 at 6:20 p.m., trained medication aide (TMA)-A denied knowledge of anticoagulant concerns with R3; however, on 9/15/23 R3's warfarin was not found in the facility, and they awaited it from pharmacy. She explained registered nurse (RN)-B took over around 6:00 p.m., thus, she was unsure if it was administered. She was unsure if she updated RN-B that evening; however, she updated LPN-E before she left. She denied management staff questioned her on any potential concerns related to R3 or that she was provided recent education related to anticoagulant therapy and/or associated processes. A Thrifty White Pharmacy packing slip report,	21545		

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21545	Continued From page 38 dated 9/15/23, identified four 1 mg warfarin tablets were brought to the facility for R3 which would have covered the 9/15/23 order. During interview on 9/19/23 at 6:43 p.m., management LPN-E explained after an order was initially processed another nurse, typically the night nurse, was expected to double check the order to decrease any potential processing errors. She reviewed R3's anticoagulant therapy orders and the MARs from 8/14/23 through 9/18/23. She stated the 8/28/23 INR lab order was not processed into R3's MAR and thus was not completed as ordered, no anticoagulants were administered from 8/28/23 through 9/10/23 and on 9/15/23, R3 received two more milligrams of warfarin on 9/16/23 than ordered, and enoxaparin was not administered on 9/17/23 as ordered. She was unable to explain the reason the 8/24/23, 9/11/23, and 9/15/23 orders were not double checked by a second nurse. In addition, she was unable to explain the reason for the errors other than processing concerns and a system failure related to the double check process. She was unaware of R3's missed INR lab on 8/28/23 and the missed associated warfarin orders, or of ACC's communicated concerns; however, she was aware of the three medication errors that started on 9/15/23. She explained the facility had not started an investigation or staff education into any of R3's medication errors and had yet to complete medication error reports for the 9/16/23 and 9/17/23 incidents. LPN-E stated if a medication was missed, the medical provider was expected to be updated. She was unsure if R3's provider was updated; however, she explained being he was followed by the ACC they updated the ACC instead of the provider. In addition, she explained if a resident who required anticoagulation therapy valued an INR around	21545		

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21545	Continued From page 39 1.1, that resident was at a very high risk for clots and she would have expected monitoring above and beyond the typical monitoring the facility provided for signs and symptoms of anticoagulant therapy bleeding risk, such as monitoring for blood pooling, extremity pain, and stroke like symptoms. When interviewed on 9/20/23 at 10:15 a.m., RN-B, who was the assistant director of nursing, stated order double checks were an expected part of order processing. This was to be completed "within a day or two" after the order was initially processed and was completed by management or floor nurses if they noticed orders in the double check file. Typically, the night charge nurse completed the double checks; however, that staff member was no longer employed. An INR value of 1.1 for a resident requiring anticoagulant was a concern as that meant the blood was too thick and they were at risk for clotting. She expected the charge nurse to investigate a low INR value as they were responsible for the medications and orders that day. In addition, when INR values were low and/or subtherapeutic, she expected the charge nurse to contact the ACC and discuss a plan of action. Furthermore, she expected an assessment to be completed if a resident missed anticoagulation medication to ensure resident stability, and to update the medical provider for additional orders, especially since the risk of missed anticoagulation therapy was higher and could increase other medical complications related to clotting. It was not a facility practice to set up missed medication assessment monitoring: "We probably should." When a medication error was identified, staff were expected to complete an incident report by the end of the shift to help rule out any potential	21545		

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21545	Continued From page 40 concerns, to determine required education if applicable, and to ensure the facility's processes were completed for when errors occurred. RN-B was unaware of the concern severity related to R3's anticoagulation therapy and thus she was unsure as to what occurred or what was investigated/implemented; however, she was aware of his 9/17/23 missed enoxaparin. She explained this error occurred as the medication was not in the facility. She stated staff should have followed the on-call pharmacy processes to request the medication on 9/17/23 instead of waiting until the next day (Monday). In addition, she stated staff should have contacted the ACC or the provider to update for additional instructions as R3 was at a definite risk for clotting and another infarction with possible death. RN-B stated missed anticoagulants were a significant medication error in which R3's anticoagulation medication errors "certainly could have been harm [for R3]." During interview on 9/20/23 at 12:10 p.m., the administrator stated he was not aware of any systemic medication concerns prior to being updated on R3's anticoagulant and INR concerns after the abbreviated survey started. He expected orders to be processed as directed and was unaware of what nursing did to ensure process accuracy. If an INR value was reported to be low, he expected staff to verify the result and verify the resident was provided the ordered medication(s). In addition, he expected a root cause analysis and for the provider to be updated. He expected the nurse managers (RN-B, LPN-E) to also follow-up and fully investigate any sort of medication and/or order concern. When interviewed via telephone on 9/21/23 at 8:45 a.m., the medical director (MD)-A stated an	21545		

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21545	Continued From page 41 INR value of 1.1 for an anticoagulated resident would be suspicious as it indicated they were not provided the ordered medication, especially if there were not orders in place to decrease the anticoagulation for procedures or surgery. R3's INR values, missed 8/28/23 INR, and missed/incorrect anticoagulation therapy was discussed. A one-time missed dose would not be a significant concern; however, there was a concern for R3 due to the multiple missed medication and lower INR values. He stated the facility required an order entry process change and expected the facility to be more hypervigilant with warfarin residents. He explained at a minimum a nurse should be in charge every day "for quite a while" to review all warfarin residents to ensure they were provided ordered medication(s) and INRs were completed as ordered. In addition, he expected these residents to be monitored and the provider to at least receive an FYI (for your information) fax to update on anticoagulation concerns such as a missed anticoagulant dose(s). The immediate jeopardy that began on 8/28/23, was removed on 9/21/23, after the facility reconciled all anticoagulation orders for residents who received warfarin, which included R3, and reviewed INR orders to ensure they were properly scheduled. In addition, R3's provider was updated with no new orders provided. The medical director was updated. Incident reports on identified medication errors were completed with root cause analysis and reviewed by the QAA (quality assurance) committee. Staff education was provided to all licensed nurses and TMAs on the importance of anticoagulation medication administration and INR lab draw order compliance as well as the process for medication administration, provider notification, order	21545		

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21545	Continued From page 42 processing, and completion of ordered labs draws with communication of results. For staff not in attendance, required recorded education was to be completed before their next working shift. Furthermore, an INR Tracking Log was added to the facility anticoagulation system with daily audits initiated by nursing leadership along with weekly warfarin administration audits. Policy and procedure reviews were conducted with plan for facility QAA committee to review progress of the abatement plan weekly until further notice. Despite this removal plan and actions taken, noncompliance remained at the lower scope and severity level 2 D as the facility failed to ensure insulin (blood sugar regulator) medication was administered in accordance with physician orders for 1 of 1 residents (R6) who was provided insulin outside of ordered parameters during a medication pass observation. _____ _____ _____ R6's quarterly MDS, dated 8/10/23, indicated R6 was cognitively intact and was diagnosed with diabetes and utilized insulin seven days a week. A Endocrinology Diabetes Program progress note, dated 5/30/23, identified R6 was educated on the importance of maintaining good glycemic control due to potential complications of uncontrolled diabetes. R6 was diagnosed with type 2 diabetes mellitus with stage 3 chronic kidney disease and diabetic neuropathy requiring insulin use. The note's Plan section indicated adjusted insulin orders with NovoLog orders directing NovoLog to be given before each of R6's meals.	21545		

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21545	Continued From page 43 A NovoLog, NovoLog FlexPen Prescribing Information PDF, dated 2/23, indicated a section labeled Dosage and Administration. This directed administration "within 5 - 10 minutes before a meal ..." R6's Order Summary Report identified R6 was ordered the following: -Blood sugar (BS) checks four times a day (QID). -NovoLog FlexPen 100 unit/ml (milliliters) seven (7) units subcutaneously (SQ) three times a day (TID). Give prior to meals. -NovoLog FlexPen 100 unit/ml per sliding scale TID (0-149 = 0; 150-200 = 2; 201-251 = -4; 252-302 = 6; 303- 353 = 8; 354-404 = 10; greater than 400 call on call provider. R6's September Medication Administration Record (MAR) identified the NovoLog was scheduled for 7:30 a.m., 11:30 a.m., and 4:30 p.m. (half hour prior to mealtimes). During a medication pass observation on 9/18/23 at 12:56 p.m. (one and a half hours after scheduled), LPN-D stated R6's BS check around 11:50 a.m. was 206 and he had yet to receive his lunch time insulin. She reviewed R6's electronic MAR (eMAR) orders and calculated he required 11 units of NovoLog based on his scheduled and sliding scale instructions. She prepped the FlexPen and administered the 11 units of NovoLog insulin to R6. She exited R6's room and documented the administration in the eMAR. Immediately following, LPN-D was interviewed. She stated she provided insulin to residents after they ate as being provided insulin if they did not eat "too good" would "not be good" as their blood sugar could drop too low. LPN-D explained she	21545		

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21545	Continued From page 44 was expected to read the entire order prior to medication administration and follow the directions as ordered; however, after she reviewed R6's orders, she stated she did not read the entire order as expected and did not follow the administration directions. In addition, she stated she was not aware of the direction to provide the insulin a half hour before meals, and if she had, she would have questioned this direction and would have investigated the order to ensure a transcription error was not made as in her history of nursing it was general nursing practice to administer insulin after meals. She denied there were risks to residents, including R6, if insulin was administered after meals versus prior to as directed. A review of R6's September MAR identified the following scheduled NovoLog insulin administration documented by LPN-D: -9/5/23 7:30 a.m. dosing: BS 127. Time stamped 9:43 a.m. -9/5/23 11:30 a.m. dosing: BS 189. Time stamped 1:15 p.m. -9/6/23 7:30 a.m. dosing: BS 149. Time stamped 10:07 a.m. -9/13/23 7:30 a.m. dosing: BS 147. Time stamped 9:24 a.m. -9/13/23 11:30 a.m. dosing: BS 152. Time stamped 1:05 p.m. -9/18/23 7:30 a.m. dosing: BS 166. Time stamped 10:15 a.m. -9/18/23 11:30 a.m. dosing: BS 206. Time stamped 1:05 p.m. R6's nursing progress notes, dated 9/5/23 through 9/18/23, lacked rationalization(s) for insulin administration not being provided as ordered i.e., poor intake, illness, R6 preferences and/or refusals prior to meals.	21545		

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21545	Continued From page 45 On 9/20/23 at 10:15 a.m. RN-B was interviewed. She expected staff to follow the five rights of medication administration which included ensuring the order directions were followed. If a medication was directed to be provided before meals, she expected the medication to be given prior to meals. If there were concerns related to order directions, she expected staff to communicate with the provider and/or the pharmacy for clarification. She would be concerned if R6 was provided his NovoLog after meals as he required this before meals to prevent blood sugar spikes. When interviewed via telephone on 9/21/23 at 8:45 a.m. R6's medical provider MD-A stated the diabetic center managed R6's insulin and he would defer directions to them as they may have specific reasons why the insulin was scheduled as it was; however, he explained the typical timing of NovoLog would be five to ten minutes before meals. He explained if given prior to meals, a half hour in R6's case, the insulin would have time to peak and cover blood sugars during the meal, thus making the insulin more effective for improved blood sugar control. MD-A was concerned when updated on the medication pass observation as R6's A1C (glycosylated hemoglobin) lab was 8.1 which indicated R6's diabetes was "slightly uncontrolled." On 9/21/23 at 4:40 p.m. the diabetic NP-B was interviewed via telephone. She stated NovoLog rapid acting was typically dosed prior to meals which was a long-standing practice. She explained the general rule was to administer the insulin 15 to 30 minutes prior to meals to decrease pre-meal blood sugars, thus, assisting in blood glucose control maintenance surrounding	21545		

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21545	Continued From page 46 mealtimes when the blood sugar again would rise. If the insulin was provided after meals, the rising blood sugar acquired during the meal, on top of the blood sugar prior to the meal, would then have to be chased which led to decreased blood glucose control. An Administering Medication policy, dated 12/2012, identified medications were to be administered in a safe and timely manner, and as prescribed. It directed medications must be administered in accordance with the orders within one hour of their prescribed time, unless otherwise specified i.e., before and after meal orders. The administering staff must check the label "THREE (3) times to verify the right resident ...right dosage, right time ...before giving the medication." An Adverse Consequences and Medication Errors policy, dated 4/2014, defined a medication error as the preparation or administration of medications which were not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. Examples included, but not limited to, a medication omission, wrong dose, or wrong time. The policy directed that any resident who received any medication with potential for adverse consequence would be monitored to ensure any such consequences were promptly identified and reported and if a medication error was identified the resident would be monitored for possible medication-related adverse consequences. In the event of a significant medication-related error, immediate action was to be taken to protect the resident's safety and welfare. Examples of significant were defined as requiring medication discontinuation or dose	21545		

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21545	Continued From page 47 modification and/or life threatening. Any significant medication error was to be promptly reported to the attending provider and the error information documented in an incident report and the resident's chart. A Medication Order policy, dated 11/2014, identified the purpose of the policy was to establish uniform guidelines in the receiving and recording of medication orders. The policy lacked information related to any established guidelines for medication and/or procedural order processing. A policy related to order processing was requested. None was provided. An Anticoagulation - Clinical Protocol policy, dated 11/2018, directed staff and the physician would collaborate in ensuring anticoagulants were assessed for risk, properly prescribed, and monitored for possible complications related to supratherapeutic INR values. The policy lacked information related to ACC collaboration and their role in resident anticoagulation needs. In addition, the policy lacked information related to resident monitoring when subtherapeutic INR values are present. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication and lab order transcription/processing and administration/completion, along with medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication and lab orders were correctly transcribed and administered/performed. The quality assurance committee could monitor these	21545		

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21545	Continued From page 48 measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21545		