DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 3, 2024

Administrator
Hilltop Healthcare Rehabilitation And Skilled Nurs
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: September 5, 2024

Dear Administrator:

On September 17, 2024, we notified you a remedy was imposed. On October 1, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 27, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 2, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 17, 2024, 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 5, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
September 17, 2024

Administrator
Hilltop Healthcare Rehabilitation And Skilled Nurs
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: September 5, 2024

Dear Administrator:

On September 5, 2024, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On September 4, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 - Free of Accident Hazards/Supervision/Devices was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 2, 2024.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 2, 2024, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 2, 2024, (42 CFR 488.417 (b)).

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Hilltop Healthcare Rehabilitation And Skilled Nurs is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 5, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of

compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 5, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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

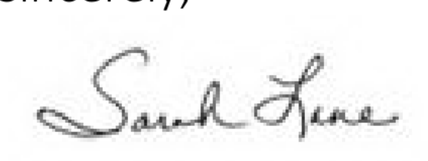
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 17, 2024

Administrator
Hilltop Healthcare Rehabilitation And Skilled Nurs
2501 Rice Lake Road
Duluth, MN 55811

Re: Event ID: YV8G11

Dear Administrator:

The above facility survey was completed on September 5, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

(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 8/29/24, through 9/5/24, an abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were reviewed: H53666892C (MN00105777) H53667067C (MN00105774) H53667620C (MN00105775) Deficiencies were issued at F689, F944 and F947. The survey resulted in an Immediate Jeopardy (IJ) at F689 related to the facility failed to provide proper supervision during meals to prevent choking for 2 of 3 residents (R1, R2) who required 1:1 supervision during meals. The administrator and director of nursing (DON) were informed of the IJ on at 9/3/24 at 5:07 p.m. The immediate jeopardy began on 8/13/24 when R2 was found alone at the dining table sleeping with food in his mouth. The IJ was removed on 9/4/24, but noncompliance remained at the lower scope and severity level of D - isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices	F 689		9/27/24

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

Electronically Signed | 09/23/2024

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 689	Continued From page 1 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper supervision during meals to prevent choking for 2 of 3 residents (R1, R2) who required 1:1 supervision during meals. This deficient practice resulted in an immediate jeopardy (IJ) for R1 and R2 when they were not provided 1:1 supervision during meals, and R1 had a coughing episode and R2 fell asleep with food in his mouth. The IJ began on 8/13/24 when R2 was found alone at the dining table sleeping with food in his mouth. The director of nursing (DON) and administrator were notified of the immediate jeopardy at 5:07 p.m. on 9/3/24. The IJ was removed on 9/4/24, but noncompliance remained at the lower scope and severity level of D - isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's Provider Orders dated 7/8/24, indicated R1 had a regular diet with chopped texture, and nectar mild thick liquids.	F 689	F689 Immediate Corrective action: • Care plans/ Kardex updated for R1 and R2 to reflect current ST suggestions • FMP Procedure (Updated) • ADL – Meal assistance policy (Updated) • IDT has been educated on FMP procedure. • IDT has been educated on ADL – Meal Assistance Policy. • All staff have been educated on FMP procedure. • All staff have been educated on ADL – Meal Assistance Policy. • Post quiz given to staff post education. • R2 no longer resides at the facility Identification of other residents: Area of risk has been identified as any resident requiring supervision and/or assistance. Corrective Action: • All residents with adaptive equipment and altered diet texture and consistencies	

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F 689	Continued From page 2 R1's admission Minimum Data Set (MDS) dated 7/8/24, indicated R1 held food in his mouth and cheeks, or held residual food in his mouth after meals. R1 was on a mechanically altered diet, and needed limited assistance with eating. R1's care plan dated 7/2/24, indicated R1 had dysphagia (difficulty swallowing) and needed 1:1 close supervision in dining room for meals. R1 also required cues to alternate small bites and small sips, and take multiple swallows to clear food from his mouth and avoid choking. On 8/1/24 a therapy progress note written by physical therapist (PT)-A indicated trained medical assistant (TMA)-A administered R1's medications in the therapy gym. R1 became red in the face and attempted to cough, but was he was unsuccessful with clearing the medications by coughing. R1's inhalation was noted to be very wet (occurs when lungs fill with fluid and not air) PT-A provided three back thrusts to R1 when coughing, and R1 coughed up one large pill. R1 continued to have wet inhalation and exhalation with a poor cough. PT-A provided five more back thrusts, and R1 was able to clear a small amount of applesauce and one small white pill. R1 coughed intermittently throughout the session, and coughed up one more large white pill. PT-A notified licensed practical nurse (LPN)-A of the incident. On 8/1/24, at 3:50 p.m. an email from PT-A was sent to the DON, administrator, and facility nurse managers, and indicated R1 had a severe choking episode with his medications that morning. R1 needed back thrusts from PT-A several times cough up medications he was choking on. PT-A	F 689	were auditing between meal tracker and PCC, all care plans updated. • Any residents with supervision or assistance needed, care plans were updated with same language as policy. • FMP Procedure (Updated) • ADL – Meal assistance policy (Updated) Monitoring/Audits: DON/Designee shall audit 5 residents care plan daily X 5 days, 2 X weekly X2 Weeks, Weekly X 2 weeks. DON/Designee shall audit 5 at meal times daily X 5 days, 2 X weekly X2 Weeks, Weekly X 2 weeks. All issues will be reported to the administrator and brought to QAPI. Alleged compliance: 9/27/2024	

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F 689	Continued From page 3	F 689		

was concerned R1 aspirated (breathed liquid or food into lungs) as he continued to cough for 30 minutes. PT-A had notified LPN-A.

A Therapy Note dated 8/2/24 written by speech therapist (ST)-A, indicated R1 needed 1:1 assistance/close supervision at all mealtimes due to him being a choking risk.

On 8/29/24 a therapy progress note written by PT-A indicated R1 was at the breakfast table, and PT-A heard R1 coughing heavily with a mouth full of food. R1 was able to scoop food out of his mouth with his hands. Nursing staff was notified R1 needed to be on 1:1 supervision with meals, and there were no staff in the dining area with R1 when he began coughing.

On 8/29/24 at 9:35 a.m. an email from physical therapy sent to the DON, administrator, and RN-A indicated R1 was on a chopped diet, and continued to have coughing episodes with eating. The note indicated R1 was not being supervised during meals. R1's meal ticket and speech recommendations indicated R1 should be on 1:1 supervision with meals which was not happening.

R1's medical record lacked indicaton of the coughing episodes on 8/1/24 and 8/29/24.

On 8/30/24 at 8:48 a.m., R1 was observed being given his meal of scrambled eggs, chopped coffee cake with syrup, oatmeal, and nectar thick milk. R1 was sitting at a table alone with his back towards the nurse's station. Three nursing assistants were in the dining area were passing trays, but no staff were providing R1 with 1:1

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F 689	Continued From page 4	F 689		

supervision. R1 was putting spoonful's of the coffee cake in his mouth before swallowing the previous bite. R1 did not cough or choke during the observation. At 8:56 a.m., nursing assistant (NA)-A was called to the nurse's station by RN-A. NA-A came back into the dining area, and sat with R1 while he was feeding himself.

On 8/30/24 at 9:05 a.m., NA-A got up for the table as R1 was still eating, went out of the dining room talked with a staff member. NA-A came back to the dining room less than a minute later and patted another resident at a different table on the back to say hello, went back to R1's table and stood next to the table. R1's meal ticket indicated supervision at all meals.

R2's Provider Orders dated 8/12/24, indicated regular diet with chopped texture and thin liquids.

R2's admission MDS dated 8/15/24, indicated R2 had aphasia (disorder that affects communication), had a mechanically altered diet, no swallowing disorder, and needed supervision when eating.

R2's care plan revised 8/14/24, indicated R2 needed 1:1 supervision and assist with all meals.

On 8/13/24 a therapy progress note written by PT-A indicated R2 was found in the dining room hunched over toward his left side. R2's mouth was closed with visible pocketing of food in his left cheek. R2 was unarousable to sternal rub (firm rub on sternum) and trap pinch (gripping and twisting of trapezius muscle in shoulder). PT-A questioned staff on how long R2 had been like that, and staff stated he was tired. After several minutes, R2 was

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HILLTOP HEALTHCARE REHABILITATION AND SKILLED NURS	2501 RICE LAKE ROAD DULUTH, MN 55811

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F 689	Continued From page 5 aroused and able to swallow the food in his mouth. The nurse manager was notified. On 8/13/24 at 1:09 p.m. an email from therapy sent to RN-D, the DON, and the therapy director asked if R2 could be placed within staff's line of sight for meals. PT-A found him at the table with food in his mouth slumped over. He required multiple sternal rubs, trap pinch, and shaking to arouse. On 8/30/24 at 8:09 a.m., R2 was observed being given his meal of chocolate milk, scrambled eggs, chopped coffee cake with syrup, oatmeal, orange juice and coffee. R2 was not being provided with 1:1 supervision. R2 was eating at a fast pace, and was not swallowing what was in his mouth prior to putting more food in his mouth. R2 was drinking fluids while eating. Four staff members (NA-B, NA-C, NA-D and one unidentified staff) were in the dining room passing meal trays, and no staff was sitting with R2, or cued him to slow down. On 8/30/24 at 12:10 p.m., R2 was observed being served his lunch. R1 had white bread with the crust cut off, parmesan zucchini casserole, broccoli, peach chunks, and milk. Staff did not provide him with 1:1 supervision. On 8/30/24 at 9:13 a.m., NA-A stated R1 needed 1:1 supervision with all of his meals, and that plan had been in place for a few weeks. R1 required staff to sit next to him because he would stuff his mouth with food, and staff would have to remind him to slow down. On 8/30/24 at 11:16 a.m., R1 was interviewed and	F 689		

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F 689	Continued From page 6 was able to shake/nod his head with yes or no answers. When asked if staff sat with him for all of his meals, R1 shook his head no. When asked if he had ever choked on his food or medications at the facility, R1 nodded his head yes. When asked if he had choked recently, R1 nodded his head yes. On 8/30/24 at 11:24 a.m., health unit coordinator (HUC)-A stated she had never seen R2 with 1:1 supervision during meals when she worked. She sat at the 2nd floor desk and had direct vision of the dining room. On 8/13/24 she saw R1 asleep at the table with food in his mouth, and no staff were around. HUC-A did not alert any of the staff he was asleep with food in his mouth, nursing staff were aware of who needed assistance as it was listed at the desk. On 8/30/24 at 12:34 p.m., NA-B stated 1:1 supervision with meals meant staff needed to sit next to the resident to make sure they did not choke. She had never seen R2 with 1:1 supervision with meals. She had been told only 10 minutes ago R2 required 1:1 supervision, and that was why no one was sitting with him during his lunch meal. On 8/30/24 at 12:39 p.m., NA-A stated they were passing trays at breakfast time, and that was why no staff were providing 1:1 supervision with R1 at the beginning of breakfast. NA-A stated 1:1 supervision meant someone needed to be right next to R1. On 8/30/24 at 1:09 p.m., R2 stated since he was admitted to the facility, no staff had ever sat with	F 689		

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F 689	Continued From page 7 him during meals. On 8/30/24 at 1:36 p.m., ST-A stated she recommended R1 have 1:1 close supervision at all meals, and this was not happening. When she recommended 1:1 supervision, it meant nursing staff were to sit with the resident when they received their meal until they were done eating. It also meant staff needed to provide cues while eating. R1 had swallowing impairments, had a modified diet, and would shovel food in his mouth. If R1 did not have 1:1 supervision with meals, he could choke, aspirate, or possibly die. R2 was recommended to have 1:1 supervision with all meals. She had seen R2 eating alone in the dining room without 1:1 supervision. On 8/30/24 at 1:49 p.m., NA-C stated staff does not sit with R2 during meals, he normally eats alone. On 8/30/24 at 1:55 p.m., occupational therapist (OT)-A stated R1 had not had 1:1 supervision during meals on more than one occasion, but was unable to identify dates or meal times when this had occurred. On 9/3/24 at 6:58 a.m., LPN-A stated on 8/1/24 after the choking incident with R1 in the therapy room, the facility had switched his medications to being crushed per therapy request after ST-A saw R1. She was unaware if R1's provider had given an order for crushed medications, or if pharmacy was aware. On 9/3/24 at 7:18 a.m., TMA-A stated on 8/1/24 after R1 choked on his medications, ST-A saw him	F 689		

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F 689	Continued From page 8 right away and stated to crush R1's medications moving forward. On 9/3/24 at 8:09 a.m., RN-A stated on 8/29/24 she received an email from the therapy department in regards to R1 coughing on his food. She emailed the nurse practitioner (NP)-A, and got orders for OT/ST to evaluate and treat R1, and an order for a swallow study to be completed. She assessed R1 on 8/29/24, and he was stable with clear lung sounds. She forgot to document her assessment and the NP update in R1's medical record. On 9/3/24 at 9:07 a.m., PT-A stated on 8/13/24, R2 was in the dining room for lunch, sitting alson at a table hunched over in his chair. She could see food in R2's mouth. She tried a sternal rub and trap pinch on R1, but he was not waking up. NA staff came over and they where able to arouse him. On 8/29/24 at breakfast, R1 was sitting at a table in the dining room without 1:1 staff supervision, and was shoveling food into his mouth. She tried to cue R1 to stop, and he started scooping the food out of his mouth with his hands as he was coughing. There was no staff to provide R1 with 1:1 supervision, so she stayed with him while he ate. She sent an email to management about the incident. PT-A stated the response she got from management was R2 was just "tired." On 9/3/24 at 9:23 a.m., HUC-A stated on 8/13/24, at lunch time R2 was sitting at the table in and out of sleep as he was eating. No one was sitting with R2, there was a nursing assistant in the dining room at first, but then they left the area as R2 was still eating. PT-A then came to the unit and R2	F 689		

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F 689	Continued From page 9 was asleep with food in his mouth. PT-A tried to wake R2, she finally got R2 to open his eye after several minutes, and there were still no NAs around. On 9/3/24 at 9:30 a.m., ST-A stated R2 had a history of aspiration prior to being at the facility. On 9/3/24 at 9:31 a.m., the medical director (MD)-A stated he was aware of the concerns with 1:1 supervision during meals, and this was not being followed at the facility. Staff were expected to follow ST recommendations. If a resident was coughing on their food, a nurse should be notified to assess the resident, including putting the assessment in the resident's medical record. On 9/3/24 at 9:39 a.m., RN-E stated on 8/29/24 in the morning, therapy came to her and stated R1 had too many sausages in his mouth. When RN-E went into the dining room, PT and OT were the only ones with R1. NAs were passing trays. R1 was supposed to have supervision with him when he was eating, She was not sure how far from R1 they could be when providing supervision, so RN-E kept "an eye: on him." On 9/3/24 at 9:44 a.m., DON stated staff were to follow the residents care plan and assist them per therapy recommendations. 1:1 supervision meant staff were to sit next to a resident when they were eating. On 9/3/24 at 9:56 a.m., the administrator stated staff were expected to follow therapy recommendations when it came to 1:1 supervision at meals.	F 689		

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F 689	Continued From page 10 On 9/3/24 at 3:56 p.m., nurse practitioner (NP)-A stated R1's diagnoses and tendencies when eating put him at high risk for aspiration pneumonia. On 9/3/24 at 4:40 p.m. (NP)-B stated R2 was at a higher risk for aspiration pneumonia due to his stroke and speech therapy concerns. The facility policy Activities of Daily Living- Dining/ Meal Assistance dated 6/8/22, directed supervision means observation while eating and 1:1 direct supervision means cueing and physical assist. The immediate jeopardy that began on 8/13/24, was removed on 9/4/24 when the facility reviewed and revised their current policy on meal assistance. The facility reviewed all resident care plans/Kardex to reflect current ST recommendations. The facility implemented a new system for therapy recommendations. The facility completed staff education on the meal assistance policy with post quiz. The facility completed audits on all residents who needed assistance or supervision with meals to ensure they were being assisted or supervised. This was verified through observation, interview and document review.	F 689		
F 944 SS=C	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.	F 944		9/27/24

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F 944	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide mandatory training on the facility specific QAPI (Quality Assurance and Performance Improvement) program to include goals and various elements of the program, how the facility intends to implement the program, staff's role in the facility's QAPI program, or how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program to all staff reviewed for QAPI training. Findings include: On 9/5/24 at 10:59 a.m., nursing assistant (NA)-C stated she does not recall ever being offered or receiving QAPI training. She would not know where to bring concerns in regards to QAPI, and does not even know what QAPI means for the facility. On 9/5/24 at 11:04 a.m., licensed practical nurse (LPN)-A stated she was not aware of ever receiving QAPI training or it being offered. She was unaware of the facility's QAPI plan. On 9/5/24 at 11:11 a.m., registered nurse (RN)-E stated she does not recall ever having QAPI training. She does not know what the QAPI plan is for the facility. On 9/5/24 at 11:21 a.m., the director of nursing (DON) stated all staff should be educated on QAPI. On 9/5/24 at 11:28 a.m., the administrator stated they discuss QAPI often, but there has been no formal education for staff by the facility.	F 944	F944 Immediate Corrective action: • Relias New hire and Annual learning plans were adjusted to include QAPI. Identification of other residents: Area of risk has been identified as all staff. Corrective Action: • All staff will be educated on QAPI prior to their next scheduled shift. • All staff enrolled in Annual QAPI courses. • QAPI policy updated to reflect New hire and annual training. • All staff will have QAPI education completed before their next scheduled shift. Monitoring/Audits: DON/Designee shall audit 5 employees relias transcripts daily X 5 days, 2 X weekly X2 Weeks, Weekly X 2 weeks. All issues will be reported to the administrator and brought to QAPI. Alleged compliance: 9/27/2024	

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F 944	Continued From page 12 Review of the facility's Relias training (computer based training program) lacked indication of QAPI training for employees.	F 944		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure completion of 12 hours of annual in-service training for 2 of 5 nursing assistants (NA-A, NA-D) reviewed for annual training. Findings include: NA-A's Relias education (facility's computer based	F 947	F947 Immediate Corrective action: • Relias New hire and Annual learning plans were adjusted to include appropriate hours. Identification of other residents: Area of risk has been identified as all CNA's.	9/27/24

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F 947	Continued From page 13 education system) indicated on 9/5/24, NA-A had 8.57 hours of the required 12 hours of training in the last 12 months. NA-D's Relias education indicated on 9/5/24, NA-D had 3.5 hours of the required 12 hours of training in the last 12 months. On 9/5/24 at 11:14 a.m., NA-A stated the facility reminded her to do her continuing education almost daily, but NA-A had forgotten to get it completed. She has several modules overdue, and that was why she had not reached her 12 hours of training this year. On 9/5/24 at 11:21 a.m., the director of nursing (DON) stated all NAs were expected to complete the training by the due date. She expected all NAs to complete their 12 hours of training each year. On 9/5/24 at 11:28 a.m., the administrator stated NAs were expected to complete their 12 hours of training on time.	F 947	Corrective Action: • All CNA were enrolled into New Hire CNA Relias modules • All CNA were enrolled into Annual CNA Relias modules • CNAs will have 12 completed hours before their next scheduled shift Monitoring/Audits: DON/Designee shall audit 5 CNA relias transcripts daily X 5 days, 2 X weekly X2 Weeks, Weekly X 2 weeks. All issues will be reported to the administrator and brought to QAPI. Alleged compliance: 9/27/2024	