Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
10/28/2024

Administrator
Fair Oaks Nursing & Rehab LLC
201 Shady Lane Drive
Wadena, MN 56482

RE: CCN: 245581
Cycle Start Date: June 27, 2024

Dear Administrator:

On August 16, 2024, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On October 18, 2024 the Minnesota Department(s) 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 September 30, 2024.

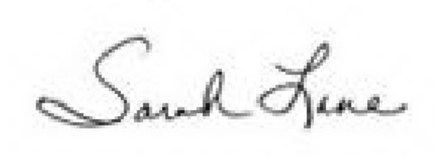
As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 27, 2024. be discontinued as of September 30, 2024. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 23, 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), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 27, 2024. This does not apply to or affect any previously imposed NATCEP loss.

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

October 28, 2024

Administrator
Fair Oaks Nursing & Rehab LLC
201 Shady Lane Drive
Wadena, MN 56482

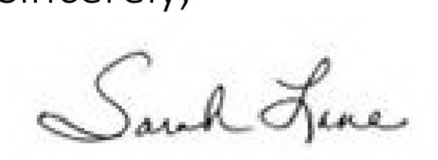
Re: Reinspection Results
Event ID: NUO512

Dear Administrator:

On August 13, 2024 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 July 10, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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Electronically delivered

July 23, 2024

Administrator
Fair Oaks Nursing & Rehab LLC
201 Shady Lane Drive
Wadena, MN 56482

RE: CCN: 245581
Cycle Start Date: June 27, 2024

Dear Administrator:

On July 10, 2024, we informed you that we may impose enforcement remedies.

On July 10, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 27, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 27, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 27, 2024.

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.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 27, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Fair Oaks Nursing & Rehab Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 27, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 December 27, 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

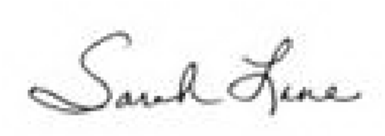
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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 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,



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
July 23, 2024

Administrator
Fair Oaks Nursing & Rehab LLC
201 Shady Lane Drive
Wadena, MN 56482

Re: State Nursing Home Licensing Orders
Event ID: NUO511

Dear Administrator:

The above facility was surveyed on July 9, 2024 through July 10, 2024 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.

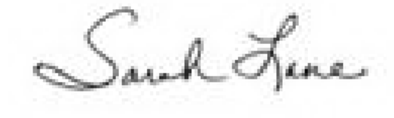
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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
4140 Thielman Lane
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,



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
	00679	A. BUILDING: _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR OAKS NURSING & REHAB LLC	201 SHADY LANE DRIVE WADENA, MN 56482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/9/24 through 7/10/24, 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 identify the date when they will be completed. The following complaints was reviewed. H55815390C (MN00104688) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	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 follow plan of care for bed mobility and incontinence cares for 1 of 3 residents (R1) reviewed for accidents, when R1 rolled off the bed and sustained a scalp hematoma and traumatic hematoma of forehead and was sent to the emergency department (ED) for a CT scan with negative results.	2 830	corrected	8/9/24

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2 830	Continued From page 3 Findings include: R1's annual Minimal Data Set (MDS) dated 6/14/24, indicated R1 had diagnoses which included obstructive hydrocephalus (a neurological disorder caused by an abnormal buildup of cerebrospinal fluid in the ventricles (cavities) deep within the brain), morbid obesity, and epilepsy. R1's care plan revised on 3/21/22, indicated R1 had impaired mobility related to obstructive hydrocephalus, history of epilepsy, major depressive disorder, anxiety disorder, diabetes, morbid obesity, pain, muscle weakness, and inability to walk. Further, R1's care plan identified R1 as Limited physical mobility with interventions listed as: does not ambulate; bed mobility assist of two, transfer full body lift assist of two, and large sling (do not use an amputee sling). FALL RISK identified as low risk she requires total assist of staff for significant movements, R1 has the potential for falls due to seizure disorder and staff error during positioning/transfers. Intervention identified as bed mobility is to be done by 2 staff at all times. Additionally, R1's Care Plan indicated she was at risk for bleeding and excessive bruising related to anticoagulant therapy related to immobility and sedentary lifestyle has history of deep vein thrombosis and embolism with interventions listed as: educate and remind resident to report any signs of bleeding or bruising to nurse, monitor for bruising bleeding with cares; monitor resident per MD orders; resident on anticoagulant therapy use caution with hands on assistance due to risk of bruising easily. Review of R1's Witnessed Fall report dated 7/7/24 at 12:50 p.m., indicated staff was called to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 4 resident's room reporting that resident had fallen out of bed. Staff was assisting with cares and had rolled resident onto her side towards the window when he realized he did not have wipes. Staff turned to grab some, letting go of resident who then fell between the bed and wall striking her head. R1's ED discharge report indicated she was seen for a right frontal forehead hematoma and occipital right scalp hematoma and anterior shoulder discomfort, range of motion tenderness located along the long head of biceps. CT findings revealed negative for acute intracranial hemorrhage or extra axial collection and hematoma X-ray of left shoulder was negative. R1 was discharged home with normal vital signs and without need for pain control. Diagnosis of: scalp hematoma and traumatic hematoma of forehead Discharge instructions: Ice can be used every 20 minutes 3-4 times per day to the area of affected swelling Medication changes: None R1's Progress Notes revealed the following: -On 7/7/24 at 12:50 p.m., writer was called to resident's room that resident was on the floor. Resident had hit her head and had a large goose egg forming to the right side of forehead and to back of head. Resident kept stating it burns, it burns. Due to Warfarin use and hitting of head writer called 911 to have resident go in for evaluation. -On 7/7/24 at 4:55 p.m., R1 returned to the facility and was alert and responsive, bruising was noted to her right eye and forehead. -On 7/8/24 at 2:42 a.m., R1 vital signs were obtained. R1 was alert and neurology checks were intact. There was bruising noted to R1's	2 830		

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FAIR OAKS NURSING & REHAB LLC	201 SHADY LANE DRIVE WADENA, MN 56482

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2 830	Continued From page 5 right forehead and eye area with no increased swelling. R1 stated she was comfortable and R1's bed was in low position for safety. R1's Order Summary Report dated 7/9/24, indicated R1 received Coumadin at bedtime related to personal history of venous thrombosis and embolism. On 7/9/24 at 12:52 p.m., R1 was observed sitting in her wheelchair in the commons area. R1 appeared comfortable and appeared to be sleeping. R1 had notable bruising, various stages of healing and coloring, around both eyes and a large bump on the right side of her face/temple. On 7/9/24 at 2:04 p.m., nursing assist (NA)-A stated he was contracted through an outside staffing agency and had been working at the facility for approximately two weeks. NA-A stated R1 required staff assistance by two staff for all activities of daily living (ADLs) which included transfers, bed mobility, and incontinent care. NA-A stated on 7/7/24, he transferred R1 into her bed using the full mechanical lift, as required, following the noon meal with assistance by registered nurse (RN)-A. NA-A stated once R1 was in bed, RN-A left R1's room, and NA-A decided to assist R1 with incontinent cares. NA-A had rolled R1 onto her left side, and NA-A noted he did not have wipes available at R1's bedside. NA-A left R1 on her left side to grab wipes from the cabinet in R1's room, when R1 rolled off her bed, which was about level with the window, and fell onto the floor. NA-A stated he ran out of the room to grab the nurse. On 7/9/24 at 2:53 p.m., RN-A stated R1 required assist of two staff for all ADLs. RN-A stated just after noon meal, she assisted NA-A transfer R1	2 830		

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	00679	A. BUILDING: _____ B. WING _____	C 07/10/2024

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2 830	Continued From page 6 into her bed using a full mechanical lift. RN-A stated after the transfer NA-B entered R1's room and RN-A was walking out of R1's room, when RN-A overheard NA-B ask NA-A if he needed any assistance with R1, and NA-A declined NA-B's offer. RN-A stated she knew R1 required assistance of two staff but did not think about it at the time of the interaction and exited the room to continue her medication pass. RN-A stated she was then notified by NA-A shortly after the interaction that R1 was on the floor. RN-A stated NA-A reported to her he went to grab wipes and let go of R1 and R1 rolled out of bed and fell to the floor. RN-A stated upon arriving at R1's room she observed R1's bed was pushed out from the wall by the window, R1 was laying on her right side and RN-A noted a contusion or "goose egg" on R1's head. RN-A stated she was aware R1 was receiving a blood thinner, so RN-A called the emergency services to evaluate R1. Further, RN-A stated R1 returned from the emergency room later the same day with no new orders, and since the accident R1 had no changes in health condition and remained at her baseline. RN-A stated staff were expected to monitor any new bruising on resident's every shift until resolved. In addition, RN-A stated she provided immediate education to NA-A following the accident regarding importance of following each resident's care plan, however RN-A was unsure if all aids received training regarding following care plans since the accident. On 7/9/24 at 3:07 p.m., NA-C stated R1 required assist of two staff for ADLs such as transfers, bed mobility and incontinence cares. NA-C stated on 7/7/24, at approximately 12:30 p.m., she was on her break and upon return NA-C stated she was informed NA-A was assisting R1 by himself and R1 had fallen out of bed. Further, NA-C stated	2 830		

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2 830	Continued From page 7 since the accident she had not received any education or training but stated the accident was "a pretty big deal" and she thought there should have been some education completed with all staff to prevent another accident. On 7/9/24 at 3:48 p.m., NA-D and NA-E confirmed there had been no recent education or training related to following care plans since R1's accident that they had received or read. On 7/10/24 at 9:59 a.m., licensed practical nurse (LPN)-A stated R1 required assist of two staff members for ADLs and LPN-A was aware R1 had an accident as evidenced by the bruising on her face however LPN-A was unsure of details related to the incident. LPN-A stated she had not received any education or training regarding following care plans since the accident. On 7/10/24 at 10:54 a.m., NA-B stated R1 was dependent on staff for all ADLS and required assistance of two staff for transfers and incontinence care. NA-B stated on 7/7/24 right after the noon meal, NA-B knew NA-A needed some assistance with R1 and as NA-B entered R1's room, RN-A was exiting. NA-B stated she had asked NA-A if anymore assistance was needed with R1's cares and NA-B declined NA-B's offer. NA-B stated she then continued to answer other resident's call lights when NA-A ran out of R1's room and stated R1 was on the floor. NA-B entered R1's room and observed R1 on the floor and R1 was stating "it burns" repeatedly, which NA-B indicated was a common phrase R1 would say when she was in pain. NA-B noted there was a bump on the front of R1's head and knew instantly R1 had a head injury so the emergency services was called. In addition, NA-B stated she had worked at the facility following the	2 830		

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2 830	Continued From page 8 accident but stated she had not received any additional training or education regarding following care plans, and she was only directed to write a statement regarding the accident and nothing else since. On 7/10/24 at 12:09 p.m., director of nursing (DON) stated she was completing the investigation related to R1's fall that occurred on 7/7/24, and DON determined NA-A did not follow R1's care plan resulting in R1 falling off her bed. DON stated NA-A was immediately educated following the accident, but DON stated she was still working on completing an all-staff education related to following care plans. DON confirmed NA-B and RN-A had not been provided education or a disciplinary action related to R1's accident as they both knew R1 required assistance of two staff members for ADLs but did not assist NA-A. Review of facility policy titled Risk Management revised 10/13/23, defined accident as an unexpected, unintended event that causes a resident serious bodily injury such as a gross hematoma or head injury. Further, policy indicated the DON would review the incident report, statements from staff involved would be gathered and further investigation would be completed. Further, a root cause analysis would be completed, and recommendations would be made for preventative measures based on the root cause. 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	2 830		

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2 830	Continued From page 9 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		

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F 000	INITIAL COMMENTS On 7/9/24 through 7/10/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H55815390C (MN00104688) with a deficiency issued at F689 and F684. As a result of the investigation, an additional deficiency was cited at F880. 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 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	F 684		8/9/24

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

Electronically Signed | 08/02/2024

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 684	Continued From page 1 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 observation, interview, and document review, the facility failed to monitor for healing and complete neuro checks for 1 of 3 residents (R1), who rolled off the bed and sustained a scalp hematoma and traumatic hematoma of forehead. Findings include: R1's annual Minimal Data Set (MDS) dated 6/14/24, indicated R1 had diagnoses which included obstructive hydrocephalus (a neurological disorder caused by an abnormal buildup of cerebrospinal fluid in the ventricles (cavities) deep within the brain), morbid obesity, and epilepsy. R1's care plan revised on 3/21/22, indicated R1 had impaired mobility related to obstructive hydrocephalus, history of epilepsy, major depressive disorder, anxiety disorder, diabetes, morbid obesity, pain, muscle weakness, and inability to walk. Additionally, R1's Care Plan indicated she was at risk for bleeding and excessive bruising related to anticoagulant therapy related to immobility and sedentary lifestyle has history of deep vein thrombosis and embolism with interventions listed as: educate and remind resident to report any signs of bleeding or bruising to nurse, monitor for bruising bleeding with cares; monitor resident per MD orders; resident on anticoagulant therapy use caution with hands on assistance due to risk of bruising easily.	F 684	F684 (SS=D) Quality of Care How corrective action will be accomplished for those residents found to have been affected by the deficient. • Orders were put into place to ensure bruising was monitored until healed. • Neuros were initiated immediately for 72 hours. • Staff working were immediately re-educated on post fall monitoring and re-evaluation. • Post fall assessments were completed for the first 72 hours. How the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. • All nursing staff were re-educated on Post Fall policy, monitoring after a fall, and re-evaluation after a fall. • All fall packets were ensured to have a neuro and vital sheet included. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits will be completed 3x weekly for 1 month, 2x per week for 1 month, and 1x per week for 1 month to ensure all residents who fall have a post fall	

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F 684	Continued From page 2 Review of R1's Witnessed Fall report dated 7/7/24 at 12:50 p.m., indicated staff was called to resident's room reporting that resident had fallen out of bed. Staff was assisting with cares and had rolled resident onto her side towards the window when he realized he did not have wipes. Staff turned to grab some, letting go of resident who then fell between the bed and wall striking her head. R1's ED discharge report indicated she was seen for a right frontal forehead hematoma and occipital right scalp hematoma and anterior shoulder discomfort, range of motion tenderness located along the long head of biceps. CT findings revealed negative for acute intracranial hemorrhage or extra axial collection and hematoma X-ray of left shoulder was negative. R1 was discharged home with normal vital signs and without need for pain control. Diagnosis of: scalp hematoma and traumatic hematoma of forehead Discharge instructions: Ice can be used every 20 minutes 3-4 times per day to the area of affected swelling Medication changes: None R1's Progress Notes revealed the following: -On 7/7/24 at 12:50 p.m., writer was called to resident's room that resident was on the floor. Resident had hit her head and had a large goose egg forming to the right side of forehead and to back of head. Resident kept stating it burns, it burns. Due to Warfarin use and hitting of head writer called 911 to have resident go in for evaluation. -On 7/7/24 at 4:55 p.m., R1 returned to the facility and was alert and responsive, bruising was noted to her right eye and forehead.	F 684	completed, neuros as needed, and monitoring orders put in place as needed. Review and analysis of these audits will be reviewed at QAPI to determine ongoing frequency and duration of audits. Date of compliance: 8/09/2024 Person responsible: Director of Nursing	

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F 684	Continued From page 3 -On 7/8/24 at 2:42 a.m., R1 vital signs were obtained. R1 was alert and neurology checks were intact. There was bruising noted to R1's right forehead and eye area with no increased swelling. R1 stated she was comfortable and R1's bed was in low position for safety. R1's progress notes lacked evidence of R1's bruising being monitored following the accident, as well ongoing neurological checks for the initial 72 hours post fall. R1's Order Summary Report dated 7/9/24, indicated R1 received Coumadin at bedtime related to personal history of venous thrombosis and embolism. Further, R1's orders lacked evidence of monitoring bruising from the accident and lacked evidence of neurological checks being completed. On 7/9/24 at 12:52 p.m., R1 was observed sitting in her wheelchair in the commons area. R1 appeared comfortable and appeared to be sleeping. R1 had notable bruising, various stages of healing and coloring, around both eyes and a large bump on the right side of her face/temple. On 7/9/24 at 2:04 p.m., nursing assist (NA)-A stated he was contracted through an outside staffing agency and had been working at the facility for approximately two weeks. NA-A stated R1 required staff assistance by two staff for all activities of daily living (ADLs) which included transfers, bed mobility, and incontinent care. NA-A stated on 7/7/24, he transferred R1 into her bed using the full mechanical lift, as required, following the noon meal with assistance by registered nurse (RN)-A. NA-A stated once R1 was in bed, RN-A left R1's room, and NA-A	F 684		

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F 684	Continued From page 4 decided to assist R1 with incontinent cares. NA-A had rolled R1 onto her left side, and NA-A noted he did not have wipes available at R1's bedside. NA-A left R1 on her left side to grab wipes from the cabinet in R1's room, when R1 rolled off her bed, which was about level with the window, and fell onto the floor. NA-A stated he ran out of the room to grab the nurse. On 7/9/24 at 2:53 p.m., RN-A stated R1 returned from the emergency room later the same day with no new orders, and since the accident R1 had no changes in health condition and remained at her baseline. RN-A stated staff were expected to monitor any new bruising on resident every shift until resolved. On 7/10/24 at 11:21 a.m., RN-B stated staff were expected to monitor a resident's injuries every shift until resolved and a nursing order would be placed on the resident's treatment administration record (TAR). RN-B stated there was no monitoring for R1's bruising in her record. Further, RN-B stated neurological checks were expected to be obtained by staff following an unwitnessed fall or a fall with a head strike for three days, however RN-B stated she was unable to locate R1's neurological checks and was unsure if they were completed following R1's accident. On 7/10/24 at 12:09 p.m., director of nursing (DON) stated staff were expected to monitor a resident's injury until healed and would be added to the resident's treatment record, however DON confirmed she did not add a treatment order for staff to monitor R1's facial bruising following the accident. In addition, DON stated staff were expected to obtain neurological checks for 72	F 684		

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F 684	Continued From page 5 hours following a fall with a head strike however DON confirmed R1's neurological checks were unable to be located and stated staff would still be expected to be obtaining them as it had not been 72 hours since R1's accident. Review of facility policy titled Post Fall Policy revised 10/23/23, revealed staff would be expected to document on resident's condition at minimum of every shift for 72 hours which would include relevant post-fall findings such as vital signs, pain, bruising and changes in function as well as monitor for signs of head injury.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow plan of care for bed mobility and incontinence cares for 1 of 3 residents (R1) reviewed for accidents, when R1 rolled off the bed and sustained a scalp hematoma and traumatic hematoma of forehead and was sent to the emergency department (ED) for a CT scan with negative results. Findings include: R1's annual Minimal Data Set (MDS) dated	F 689	F689 (SS=D) Free of Accident Hazards/Supervision/Devices How corrective action will be accomplished for those residents found to have been affected by the deficient. • Internal investigation was completed. • All staff were re-educated immediately if they were on shift and before their next shift that they were to follow all the residents' care plan. • Interdisciplinary Team members were re-educated on the risk management	8/9/24

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F 689	Continued From page 6 6/14/24, indicated R1 had diagnoses which included obstructive hydrocephalus (a neurological disorder caused by an abnormal buildup of cerebrospinal fluid in the ventricles (cavities) deep within the brain), morbid obesity, and epilepsy. R1's care plan revised on 3/21/22, indicated R1 had impaired mobility related to obstructive hydrocephalus, history of epilepsy, major depressive disorder, anxiety disorder, diabetes, morbid obesity, pain, muscle weakness, and inability to walk. Further, R1's care plan identified R1 as Limited physical mobility with interventions listed as: does not ambulate; bed mobility assist of two, transfer full body lift assist of two, and large sling (do not use an amputee sling). FALL RISK identified as low risk she requires total assist of staff for significant movements, R1 has the potential for falls due to seizure disorder and staff error during positioning/transfers. Intervention identified as bed mobility is to be done by 2 staff at all times. Additionally, R1's Care Plan indicated she was at risk for bleeding and excessive bruising related to anticoagulant therapy related to immobility and sedentary lifestyle has history of deep vein thrombosis and embolism with interventions listed as: educate and remind resident to report any signs of bleeding or bruising to nurse, monitor for bruising bleeding with cares; monitor resident per MD orders; resident on anticoagulant therapy use caution with hands on assistance due to risk of bruising easily. Review of R1's Witnessed Fall report dated 7/7/24 at 12:50 p.m., indicated staff was called to resident's room reporting that resident had fallen out of bed. Staff was assisting with cares and had	F 689	policy. How the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. • All nursing staff have been re-educated on following all residents' care plan. • Interdisciplinary Team members were re-educated on the risk management policy. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits on risk managements to ensure that an incident report is completed, reported to the proper leaders, investigated, and reviewed by the IDT. Audits will be completed 3x weekly for 1 month, 2x per week for 1 month, and 1x per week for 1 month. Review and analysis of these audits will be reviewed at QAPI to determine ongoing frequency and duration of audits. Date of compliance: 8/09/2024 Person responsible: Administrator	

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F 689	Continued From page 7 rolled resident onto her side towards the window when he realized he did not have wipes. Staff turned to grab some, letting go of resident who then fell between the bed and wall striking her head. R1's ED discharge report indicated she was seen for a right frontal forehead hematoma and occipital right scalp hematoma and anterior shoulder discomfort, range of motion tenderness located along the long head of biceps. CT findings revealed negative for acute intracranial hemorrhage or extra axial collection and hematoma X-ray of left shoulder was negative. R1 was discharged home with normal vital signs and without need for pain control. Diagnosis of: scalp hematoma and traumatic hematoma of forehead Discharge instructions: Ice can be used every 20 minutes 3-4 times per day to the area of affected swelling Medication changes: None R1's Progress Notes revealed the following: -On 7/7/24 at 12:50 p.m., writer was called to resident's room that resident was on the floor. Resident had hit her head and had a large goose egg forming to the right side of forehead and to back of head. Resident kept stating it burns, it burns. Due to Warfarin use and hitting of head writer called 911 to have resident go in for evaluation. -On 7/7/24 at 4:55 p.m., R1 returned to the facility and was alert and responsive, bruising was noted to her right eye and forehead. -On 7/8/24 at 2:42 a.m., R1 vital signs were obtained. R1 was alert and neurology checks were intact. There was bruising noted to R1's right forehead and eye area with no increased	F 689		

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	245581	A. BUILDING _____ B. WING _____	C 07/10/2024

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F 689	Continued From page 8	F 689		

swelling. R1 stated she was comfortable and R1's bed was in low position for safety.

R1's Order Summary Report dated 7/9/24, indicated R1 received Coumadin at bedtime related to personal history of venous thrombosis and embolism.

On 7/9/24 at 12:52 p.m., R1 was observed sitting in her wheelchair in the commons area. R1 appeared comfortable and appeared to be sleeping. R1 had notable bruising, various stages of healing and coloring, around both eyes and a large bump on the right side of her face/temple.

On 7/9/24 at 2:04 p.m., nursing assist (NA)-A stated he was contracted through an outside staffing agency and had been working at the facility for approximately two weeks. NA-A stated R1 required staff assistance by two staff for all activities of daily living (ADLs) which included transfers, bed mobility, and incontinent care. NA-A stated on 7/7/24, he transferred R1 into her bed using the full mechanical lift, as required, following the noon meal with assistance by registered nurse (RN)-A. NA-A stated once R1 was in bed, RN-A left R1's room, and NA-A decided to assist R1 with incontinent cares. NA-A had rolled R1 onto her left side, and NA-A noted he did not have wipes available at R1's bedside. NA-A left R1 on her left side to grab wipes from the cabinet in R1's room, when R1 rolled off her bed, which was about level with the window, and fell onto the floor. NA-A stated he ran out of the room to grab the nurse.

On 7/9/24 at 2:53 p.m., RN-A stated R1 required assist of two staff for all ADLs. RN-A stated just after noon meal, she assisted NA-A transfer R1

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F 689	Continued From page 9 into her bed using a full mechanical lift. RN-A stated after the transfer NA-B entered R1's room and RN-A was walking out of R1's room, when RN-A overheard NA-B ask NA-A if he needed any assistance with R1, and NA-A declined NA-B's offer. RN-A stated she knew R1 required assistance of two staff but did not think about it at the time of the interaction and exited the room to continue her medication pass. RN-A stated she was then notified by NA-A shortly after the interaction that R1 was on the floor. RN-A stated NA-A reported to her he went to grab wipes and let go of R1 and R1 rolled out of bed and fell to the floor. RN-A stated upon arriving at R1's room she observed R1's bed was pushed out from the wall by the window, R1 was laying on her right side and RN-A noted a contusion or "goose egg" on R1's head. RN-A stated she was aware R1 was receiving a blood thinner, so RN-A called the emergency services to evaluate R1. Further, RN-A stated R1 returned from the emergency room later the same day with no new orders, and since the accident R1 had no changes in health condition and remained at her baseline. RN-A stated staff were expected to monitor any new bruising on resident's every shift until resolved. In addition, RN-A stated she provided immediate education to NA-A following the accident regarding importance of following each resident's care plan, however RN-A was unsure if all aids received training regarding following care plans since the accident. On 7/9/24 at 3:07 p.m., NA-C stated R1 required assist of two staff for ADLs such as transfers, bed mobility and incontinence cares. NA-C stated on 7/7/24, at approximately 12:30 p.m., she was on her break and upon return NA-C stated she was informed NA-A was assisting R1 by himself and	F 689		

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F 689	Continued From page 10 R1 had fallen out of bed. Further, NA-C stated since the accident she had not received any education or training but stated the accident was "a pretty big deal" and she thought there should have been some education completed with all staff to prevent another accident. On 7/9/24 at 3:48 p.m., NA-D and NA-E confirmed there had been no recent education or training related to following care plans since R1's accident that they had received or read. On 7/10/24 at 9:59 a.m., licensed practical nurse (LPN)-A stated R1 required assist of two staff members for ADLs and LPN-A was aware R1 had an accident as evidenced by the bruising on her face however LPN-A was unsure of details related to the incident. LPN-A stated she had not received any education or training regarding following care plans since the accident. On 7/10/24 at 10:54 a.m., NA-B stated R1 was dependent on staff for all ADLS and required assistance of two staff for transfers and incontinence care. NA-B stated on 7/7/24 right after the noon meal, NA-B knew NA-A needed some assistance with R1 and as NA-B entered R1's room, RN-A was exiting. NA-B stated she had asked NA-A if anymore assistance was needed with R1's cares and NA-B declined NA-B's offer. NA-B stated she then continued to answer other resident's call lights when NA-A ran out of R1's room and stated R1 was on the floor. NA-B entered R1's room and observed R1 on the floor and R1 was stating "it burns" repeatedly, which NA-B indicated was a common phrase R1 would say when she was in pain. NA-B noted there was a bump on the front of R1's head and knew instantly R1 had a head injury so the	F 689		

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F 689	Continued From page 11 emergency services was called. In addition, NA-B stated she had worked at the facility following the accident but stated she had not received any additional training or education regarding following care plans, and she was only directed to write a statement regarding the accident and nothing else since. On 7/10/24 at 12:09 p.m., director of nursing (DON) stated she was completing the investigation related to R1's fall that occurred on 7/7/24, and DON determined NA-A did not follow R1's care plan resulting in R1 falling off her bed. DON stated NA-A was immediately educated following the accident, but DON stated she was still working on completing an all-staff education related to following care plans. DON confirmed NA-B and RN-A had not been provided education or a disciplinary action related to R1's accident as they both knew R1 required assistance of two staff members for ADLs but did not assist NA-A. Review of facility policy titled Risk Management revised 10/13/23, defined accident as an unexpected, unintended event that causes a resident serious bodily injury such as a gross hematoma or head injury. Further, policy indicated the DON would review the incident report, statements from staff involved would be gathered and further investigation would be completed. Further, a root cause analysis would be completed, and recommendations would be made for preventative measures based on the root cause.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		8/9/24

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F 880	Continued From page 12 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 13 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow enhanced barrier precautions while providing high contact direct care for 1 of 2 (R1) residents reviewed. Findings include: R1's annual Minimal Data Set (MDS) dated 6/14/24, indicated R1 had a diagnosis of extended spectrum beta lactamase (EBSL) resistance (enzymes that confer resistance to most beta-lactam antibiotics, including penicillin, cephalosporins, and the monobactam	F 880	F880 (SS=D) Infection Prevention & Control How corrective action will be accomplished for those residents found to have been affected by the deficient. • All nursing and care staff members that were working were immediately re-educated on Enhanced Barrier Precautions and how to identify residents on Enhanced Barrier Precautions, including education on why R1 needed to be on Enhanced Barrier Precaution and why not wearing them could impact	

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F 880	Continued From page 14 aztreonam). R1's care plan revised on 3/21/22, indicated R1 had impaired mobility related to obstructive hydrocephalus, history of epilepsy, major depressive disorder, anxiety disorder, diabetes, morbid obesity, pain, muscle weakness, and inability to walk. Further, R1's care plan identified R1 required assist of two staff for bed mobility and toileting. However, R1's care plan lacked evidence of R1 requiring enhanced barrier precautions. On 7/9/24 at 12:56 p.m., R1's door was closed with a sign posted outside of the door indicating R1 required enhanced barrier precautions and directed staff to wear gloves and a gown for the following high contact resident care activities: dressing, transferring, changing linens, providing hygiene, or changing briefs. Upon entering R1's room, nursing assistant (NA)-F and NA-G were transferring R1 into bed using a full mechanical lift. NA-F and NA-G removed lift sheet from under R1, removed R1's socks and began removing R1's incontinent brief. When questioned regarding signs posted outside of R1's door, NA-F and NA-G stated R1 was not on enhanced barrier precautions and stated that was for resident's who had a wound, an infection, or a catheter, and R1 did not have any of those things. NA-F and NA-G continued to provide incontinence care and hygiene without personal protective equipment (PPE) on. At approximately 1:04 p.m., NA-F and NA-F exit R1's room. On 7/9/24 at 1:05 p.m., director of nursing (DON) confirmed R1 was on enhanced barrier precautions due to a diagnosis of EBSL and staff were expected to wear PPE as directed.	F 880	resident like R1 and other residents. • All nursing and care staff members were re-educated on enhanced barrier precautions and directed staff to wear gloves and a gown for the following high contact resident care activities: dressing, transferring, changing linens, providing hygiene, or changing briefs. • All nursing and care staff members were re-educated on the importance of wearing Enhanced Barrier Precautions for residents who have extended spectrum beta lactamase (EBSL). How the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents who are on Enhanced Barrier Precautions have the potential to be affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. • All staff members were re-educated on the Enhanced Barrier Precautions policy and identifying who is on Enhanced Barrier Precautions. • All nursing and care staff members were re-educated on enhanced barrier precautions and directed staff to wear gloves and a gown for the following high contact resident care activities: dressing, transferring, changing linens, providing hygiene, or changing briefs. • All nursing and care staff members were re-educated on the importance of wearing Enhanced Barrier Precautions for residents who have extended spectrum beta lactamase (EBSL). How the facility will monitor its corrective	

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F 880	Continued From page 15 Review of facility policy titled Enhanced Barrier Precautions (EBP) dated 3/26/24, indicated EBP would be implemented during high-contact resident care activities when caring for residents that had an increased risk for acquiring a multidrug-resistant organism (MDRO). EBP will not only focus on resident with infection or colonization with MDRO's but will also address resident at risk for developing or becoming colonized. Additional MRDOs that are epidemiologically important to include was ESBL. Further policy indicated facility would post clear signage on the door/wall outside the resident's room and for resident for whom EBP are indicated, EBP would be employed when performing the following high-contact resident care activities: dressing, transferring, providing hygiene, changing linens, and changing briefs. In addition, policy stated communication and education would be provided to all staff caring for or entering resident room for directions.	F 880	actions to ensure that the deficient practice is being corrected and will not recur. Audits will be completed 3x weekly for 1 month, 2x per week for 1 month, and 1x per week for 1 month to ensure Enhanced Barrier Precautions are being followed per policy. Review and analysis of these audits will be reviewed at QAPI to determine ongoing frequency and duration of audits. Date of compliance: 8/09/2024 Person responsible: Director of Nursing	