DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 25, 2024

Administrator
St. Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

RE: CCN: 245610
Cycle Start Date: February 12, 2024

Dear Administrator:

On March 8, 2024 (revised letter), we notified you a remedy was imposed. On March 20, 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 March 13, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 15, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 8, 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 February 12, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 25, 2024

Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

Re: Reinspection Results
Event ID: OLLB12

Dear Administrator:

On March 20, 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 February 12, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
February 29, 2024

Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

RE: CCN: 245610
Cycle Start Date: February 12, 2024

Dear Administrator:

On February 12, 2024, a 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 February 9, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of J.

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 March 15, 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 March 15, 2024 (42 CFR 488.417 (b)). They will also notify the

State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 15, 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.

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 $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 12, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

If you have not achieved substantial compliance by March 15, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St. Gertrude's Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 15, 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.

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, St. Gertrude's Health & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 12, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 12, 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 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 29, 2024

Administrator
St. Gertrude's Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

Re: State Nursing Home Licensing Orders
Event ID: OLLB11

Dear Administrator:

The above facility was surveyed on February 6, 2024 through February 12, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

** This letter is to replace the letter dated February 29, 2024, to actively show the lowered scope and severity of the IJ.

Electronically Submitted
March 8, 2024

Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

RE: CCN: 245610
Cycle Start Date: February 12, 2024

Dear Administrator:

On February 12, 2024, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On February 9, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 March 15, 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 March 15, 2024, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 15, 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.

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 $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 12, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

If you have not achieved substantial compliance by March 15, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St. Gertrude's Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 15, 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.

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, St Gertrudes Health & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 12, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 12, 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 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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F 000	INITIAL COMMENTS On 2/6/24, 2/7/24, 2/8/24 and 2/12/24, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F689 began on 2/1/24, when the facility failed to comprehensively assess, develop and implement safe smoking interventions including but not limited to supervision which resulted in R2 sustaining burns to 90% of her body and died as a result of her injuries. The administrator, and director of nursing (DON) were notified of the IJ on 2/8/24 at 12:41 The IJ was removed on 2/9/24 at 4:31 p.m.. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 2/12/24. The following complaints were reviewed: H56109564C (MN100557 and MN100704) with a deficiency cited at F689 H56109563C (MN100455) with a deficiency cited at F686 and H56109667C (MN100627) with a deficiency cited at F755. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/07/2024

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 000	Continued From page 1 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 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to perform timely comprehensive skin assessments, follow physician orders to provide treatment and services to heal and prevent pressure ulcer infection for 1 of 3 residents (R1) reviewed for pressure ulcers. The facility's failure resulted in harm to R1 who developed a stage 4 pressure ulcer with osteomyelitis and associated cellulitis requiring hospitalization. Findings include:	F 686	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F686: Treatment/Svcs to Prevent/Heal	3/13/24

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F 686	Continued From page 2 Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. Stage 4 pressure ulcer: Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle tendon, ligament, cartilage, or bone in the ulcer. Slough and /or eschar may be visible on some parts of the wound bed. Unstageable pressure ulcer: Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. Osteomyelitis: an infection in a bone reached by traveling through the bloodstream or spreading from nearby tissue, treatment is usually surgery to remove portions of bone that have died, followed by strong antibiotics. R1's hospital discharge summary dated 12/7/23, identified R1 was hospitalized from 11/30/23 to 12/7/23 for right leg cellulitis (a serious bacterial infection of the skin) with discharge orders for	F 686	Pressure Ulcer CITED RESIDENT(S): R1 is no longer residing at facility and discharged on 2/2/2024. Medical Record will be reviewed for Quality Assurance purposes. LIKE RESIDENT(S): Facility expanded risk group to all residents in house with a pressure injury. Facility audit completed to ensure weekly comprehensive assessments were noted in resident□s medical record. No trends identified (or residents affected). EDUCATION: Prevention and Treatment of Skin Breakdown/Pressure Injury policy reviewed and remains current. Licensed nurses will utilize Skin Risk Assessment with Braden Scale observation in matrix to document skin impairments upon admission and weekly thereafter. Wound provider or Nursing Leadership will assess pressure injuries weekly included measurements assessing the wound bed surrounding skin, drainage, and if odor is present. All licensed nurses will be educated to update provider of any new skin impairment and if a current skin impairment is deteriorating or not healing. All licensed nurses will be educated on admission skin assessments and weekly comprehensive assessments of pressure injuries. AUDIT: Director of Nursing or Licensed Nurse Designee will audit all residents in house with a noted pressure injury weekly for 4 weeks and then monthly for 2	

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F 686	Continued From page 3 treatment of cellulitis with antibiotics and has four wounds: right knee, right lower leg, left knee and left heel. Orders to clean each wound with wound cleanser, pat dry with sterile 4 x 4 gauze, apply a 4 x 4 border dressing to each wound and change every three days and as needed if dressing becomes soiled. Heel offloading boots to bilateral legs when in bed and wheelchair do not walk in boots. R1's Skin assessment dated 12/7/23, identified R1 was at risk for pressure ulcers. The assessment did not identify any current pressure ulcers. R1's nurse practioner (NP) progress note, dated 12/8/23, does not identify any pressure ulcer to R1's left heel. R1's progress note dated 12/10/23, identified a skin assessment identified wound on heels had small serosanguinous drainage (mix of red and yellow drainage) not open. Area surrounding very tender, wound cleansed and Mepilex dressing (foam dressing) applied. The assessment did not identify the wound type, a description of wound characteristics, measurements, signs and symptoms of healing, infection or if they had any pain. R1's admission Minimum Data Set (MDS) dated 12/13/23, indicated R1's cognition was intact. R1 had diagnoses of cellulitis of lower right limb, hemiplegia (weakness on one side) and hemiparesis (paralysis on one side) following cerebral infarction (stroke) affecting left non-dominant side, dementia, bilateral hearing loss, and wound infection other than foot. R1 had impairment in range of motion (ROM) in all	F 686	months to ensure comprehensive assessment is completed. Director of Nursing or Licensed Nurse Designee will directly observe a dressing change for 2 residents in house with a noted pressure injury weekly for 4 weeks and then monthly for 2 months to ensure physician orders are being followed. Director of Nursing or Licensed Nurse Designee will audit 6 Residents to ensure a comprehensive skin assessment was completed on Admission weekly for 4 weeks and then monthly for 2 months. Audit results will be reviewed by Quality Council monthly for further actions if needed.	

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F 686	Continued From page 4 extremities, was dependent with lower body dressing, required maximal assist with transfers and used a manual wheelchair for mobility. R1 was at risk for pressure ulcers, had a stage 1 pressure ulcer, a pressure reducing device for bed and wheelchair, pressure ulcer care, and applications of dressings to feet. R1's Care Area Assessment (CAA) dated 12/13/23, indicated R1 was at risk for new or worsening pressure injury related to impaired mobility requiring assist with bed mobility, incontinence, and the use of psychotropic and diuretic medications. R1 had a stage 1 pressure injury, a pressure reducing mattress and wheelchair cushion, bilateral grab bars to assist with bed mobility, pillows utilized for positioning, heels floated in bed, staff to assess skin when providing cares and registered nurse (RN) to perform weekly body audit. R1's care plan dated 12/13/23, identified R1 was at risk for new or worsening skin impairments related to diagnosis of cellulitis in right leg. Prevention interventions dated 12/27/23, directed staff to observe pressure areas daily with cares and report any concerns to the nurse, wound nurse consultant as needed, wound care as ordered, offer turning and repositioning every two hours as needed. Care plan did not address R1's pressure ulcer to the left heel. R1's Skin assessment dated 12/14/23, identified R1 was at risk for pressure ulcers. The assessment did not identify any current pressure ulcers. R1's NP progress note dated 12/19/23, identified an unstageable pressure ulcer to R1's left heel,	F 686		

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F 686	Continued From page 5 no complaints of pain, pressure relief measures in place. Plan-in-house wound MD (medical doctor) consult, heel protectors while in bed, and offload pressure. There was no description of the unstageable pressure ulcer including characteristics, measurements, infection, or drainage. R1's wound physician progress note dated 12/20/23, identified R1 to have a stage 3 pressure ulcer to the left heel, 2.9 centimeters (cm) x 4.7 cm x 0.1 cm, wound bed had 75% granulation tissue and 25% slough with light serous exudate. Treatment order use hydrocolloid sheet (provides a protective, translucent barrier that facilitates granulation and epithelialization. Smooth, satin backing is low friction for longer wear) apply every 3 days, recommend floating heels in bed. No debridement completed due to insignificant amount of necrotic tissue and no signs of infection, monitor closely. The best medical estimate of the wound to heal with continued physician evaluation and intervention is 56 days with 80 % certainty. R1's wound physician progress note dated 12/27/23, identified R1's stage 3 pressure ulcer to the left heel, 0.9 cm x 4.7 cm x 0.1 cm, wound bed had 60% granulation tissue and 40% slough with moderate serous exudate. Treatment order changed to apply foam border dressing (designed to absorb fluid (exudate), and to maintain a moist environment) apply every 3 days, recommend floating heels in bed. No debridement completed due to insignificant amount of necrotic tissue and no signs of infection, monitor closely. Follow up within 7 days.	F 686		

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F 686	Continued From page 6 R1's wound physician progress note dated 1/3/24, identified R1's stage 3 pressure ulcer to the left heel, 2.5 cm x 3.0 cm x 0.2 cm, wound bed had 50% granulation tissue and 50% slough with moderate serous exudate. Treatment order changed to apply Medi honey (antimicrobial dressing used to draw fluid from deeper tissues to the wound surface to promote removal of devitalized tissue) with a foam border dressing apply every 3 days, also add skin prep daily, recommend floating heels in bed. No debridement completed due to non-infected heel necrosis, monitor closely. Follow up within 7 days. R1's nutritional progress note dated 1/5/24, identified skin with unspecified left heel ulcer being monitored by wound clinic and nursing, receiving a multivitamin which should help meet micronutrients needs for healing. R1's NP progress note dated 1/9/24, identified R1's left heel wound was covered with a dressing. R1 had unstageable pressure injury to left heel, followed by in house wound MD. Plan- Medi honey covered with Mepilex (absorbent foam dressing), change daily. There was no description of the unstageable pressure ulcer including characteristics, measurements, infection, or drainage. R1's wound physician progress note dated 1/10/24, identified R1's appointment was rescheduled due to being at an outside appointment. Review of record identified R1's left heel wound was not comprehensively assessed from 1/3/24 to 1/17/24 a total of 14 days. R1's NP progress note, dated 1/15/24, identified	F 686		

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F 686	Continued From page 7 R1's left heel wound was covered with a dressing. R1 had no complaints of pain, pressure relief measures in place, facility wound MD following R1. Plan- weekly wound rounds, Medi-honey to left heel cover with Mepilex, daily dressing change, heel protectors while in bed, and offload pressure. There was no description of the pressure ulcer including characteristics, measurements, infection, or drainage. R1's January 2024 treatment administration record (TAR) identified on 1/14/24, R1's left heel dressing was not completed due to dressing was not saturated, even though the physician's order identified Medi-honey to left heel with Mepilex dressing daily. R1's wound physician progress note dated 1/17/24, identified R1's pressure ulcer to the left heel advanced to stage 4, measured 2.8 cm x 3.6 cm x 0.3 cm, wound bed had 50% granulation tissue and 30% slough and 20% thick adherent devitalized necrotic tissue, exacerbated due to infection, with a moderate amount of serous exudate. Concerned with worsening heel wound and superficial infection labs ordered. Treatment order changed to apply foam border with silver dressing (used to treat infected wounds due to antimicrobial properties) apply every 3 days, also add skin prep daily, recommend floating heels in bed. Debridement completed due to increased necrosis with removal of 4.26 cm of devitalized and necrotic muscle level tissues as a result the nonviable wound bed tissue decreased from 50% to 10%. Monitor closely. Follow up within 7 days. R1's physician orders 1/17/24, and January 2024 Treatment Assessment Record (TAR) did not identify the new treatment order to apply foam	F 686		

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F 686	Continued From page 8	F 686		

dressing with silver. The record identified R1's wound was treated with Medi honey dressing until 1/26/24, causing R1 to miss 10 days of physician ordered treatment of silver dressing.

R1's progress note dated 1/17/24, identified R1's left heel pressure ulcer was not improving; wound care provider recommends - Ankle Brachial Index (ABI) test (a simple test that compares the blood pressure in the upper and lower limbs used to determine reduced blood flow) to test blood flow to the area.

R1's TAR 1/18/24, included R1's left heel wound was not healing. The TAR on 1/23/24, included odor to wound noted.

R1's NP progress note dated 1/23/24, identified left heel unstageable pressure ulcer being followed by facility wound MD, per report not healing, faint odor. Plan- ABI appointment pending, Registered Dietician (RD) consult, add Juven (a collagen supplement used to promote wound healing) twice a day, offload pressure and heel protectors.

R1's nutritional progress note dated 1/23/24, identified stage 2 pressure ulcer to the left heel being monitored by wound specialist and nursing, recently noted to be declining, had been receiving a multivitamin but no additional nutritional support related to good intake and appetite. After discussion with NP and reported decline in wound will begin Juven 1 packet twice a day.

R1's wound physician progress note dated 1/24/24, identified R1's stage 4 pressure ulcer to the left heel, 5 cm x 4 cm x 0.3 cm, wound bed had 70% granulation tissue and 30% slough with

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F 686	Continued From page 9 moderate serous exudate. Treatment order foam border dressing with silver dressing apply every 3 days, add skin prep daily, and recommend float heels in bed. No debridement completed due to non-infected heel necrosis, monitor closely. Follow up within 7 days. R1's progress note dated 1/24/24, identified R1 was seen by "wound provider" left heel odor has decreased, doppler showed blood flow to the area, has been using Prevalon heel boots, will attempt to float heels using two pillows when in bed and chair instead of heel boots. R1's progress note dated 1/26/24, identified meeting with R1 and family to discuss left heel healing status, family wondered if a culture of the wound could be completed to see if R1 would need an antibiotic. R1's TAR dated 1/16/24, included wound culture to left heel performed. Per interview on 2/14/24 at 4:16 p.m. the wound doctor reported the wound culture showed proteus mirabilis. R1's NP progress note dated 1/30/24, identified R1's left heel wound edges to be macerated (skin softening and breaking down due to prolonged contact with moisture), center of wound slough, moderate drainage. Followed by in house wound MD, wound culture obtained, white blood count (WBC) 11.2 (anything above 11 can be related to infection). Plan-vascular appointment 2/7/24, RD following, Juven twice a day, weights two times weekly, offload pressure and heel protectors. R1's wound physician progress note dated 1/31/24, identified R1's stage 4 pressure ulcer to the left heel, 5.6 cm x 7.3 cm x 0.4 cm, wound bed had 50% granulation tissue and 50% slough	F 686		

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F 686	Continued From page 10 with heavy serous exudate. Wound was exacerbated and treatment order changed to apply Medi honey with foam border dressing with apply daily with skin prep, recommend float heels in bed. Debridement completed due to the need to remove necrotic tissue and establish viable margins of viable tissue, 16.35 cm of devitalized tissue including slough, biofilm and non-viable tissue in the wound bed decreased from 50% to 10 %. Monitor closely and follow up within 7 days. R1's progress notes dated 1/31/24, wound provider rounds family present and educated on wound status and recommendations, stated R1's heel was making slight improvement. X-ray ordered to rule out osteomyelitis. R1's progress note dated 2/1/24, identified left heel X-ray results impression was a large posterior heel ulcer and underlying posterior calcaneal osteomyelitis (inflammatory condition of the bone secondary to infection). Nurse practitioner (NP) was paged with results and gave orders to send to the hospital with the new diagnosis of osteomyelitis. R1's emergency department (ED) to hospitalization progress notes dated 2/1/24 to 2/14/24, identified R1 was admitted for treatment of left heel osteomyelitis with associated cellulitis. As of 2/14/24, R1 was still hospitalized. During an interview on 2/12/24 at 1:07 p.m., family member (FM)-B stated R1 admitted to facility with a left heel blister and was planning to move to an Assisted Living facility (ALF) and ALF staff came to evaluate R1. R1 was admitted to hospital on 2/1/24 with an unstageable pressure ulcer with osteomyelitis and was on three different	F 686		

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F 686	Continued From page 11 antibiotics and would not return to the facility after hospitalization. FM-B stated "It took our family being aggressive for the facility to do anything about R1's infected left heel." During an interview on 2/12/24, at 3:06 p.m., DON indicated the admission floor nurse was responsible to remove dressings, assess and measure wounds during an admission. DON identified R1's pressure ulcer to left heel was not comprehensively assessed from admit date of 12/7/23, until the wound doctor came onboard on 12/20/23. Additionally missed a comprehensive assessment on 1/10/24 and verified the pressure ulcer went from a stage 3 to a stage 4. The assessment should include wound bed and peri wound description, measurements, signs and symptoms of infection, and drainage and to document this weekly. DON identified being wound certified and would expect a wound to be larger when Medi-honey was used. Skin assessments should be done on admission, weekly for the first four weeks, quarterly and with all significant changes. R1 had weekly wound rounds by the wound physician, if the wound physician was not available it would be the responsibility of the floor nurse to assess the wound and document it. During a phone interview on 2/12/24 at 4:16 p.m., wound doctor (WD)-A indicated a comprehensive wound assessment should be completed weekly to identify changes to help with the treatment plan for healing. WD-A stated that an addendum was made to R1's chart after a phone conversation with the DON. WD-A stated that an odor was present in the wound on 1/24/24 and discussed the need for topical antibiotics and the next week on 1/31/24 the odor was less prominent,	F 686		

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F 686	Continued From page 12 acknowledged that R1 was hospitalized with osteomyelitis to the left heel on 2/1/24. WD-A indicated he was under the impression that nursing assistants or licensed nursing staff were completing dressing changes. WD-A did feel that the wound was getting worse on the last visit (1/31/24) but that wound measurements were not always completed and WD-A admitted to sometimes "eyeballing" the wounds instead of measuring. WD-A stated that the only reason he ordered the x-ray was because the family was insistent on further testing. During an interview on 2/13/24 at 12:39 p.m., medical director (MD)-A stated, I expect wound assessments to be done on a weekly basis to determine an appropriate treatment for healing or maintaining a pressure ulcer. MD-A indicated the facility had completed some weekly assessments and missed some others. MD-A stated the facility began working with a contracted wound care company in December 2023 as facility wounds had not been properly managed and had thought things were getting better. Facility policy, "Prevention and Treatment of Skin Breakdown/Pressure Injury," dated 2018 identified a Purpose: Maintaining intact skin is integral to resident health and wellness. Care and service are delivered to maintain skin integrity and promote skin healing if skin breakdown should occur. Policy: Resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission, weekly for 4 weeks, upon significant change and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reducing the potential for skin breakdown. Those residents'	F 686		

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F 686	Continued From page 13 who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care. 3. Skin integrity is monitored, and abnormal findings are documented: o Skin is observed daily with cares. If any skin concerns are noted, they are reported to the licensed nurse. o Weekly skin audits are performed by a licensed nurse. 4. A therapy evaluation is requested as appropriate. 5. Education is provided to the resident/resident representative as indicated. II. Treatment of impaired pressure injury and lower extremity ulcers (arterial, venous, neuropathy/diabetic, or mixed). If a resident is admitted with impaired skin integrity or new pressure injury or a lower extremity ulcer develops, the licensed nurse implements the follow items: 1. Documentation of the skin impairment is completed in the medical record. Staging is completed as necessary by trained licensed nursing associates. 2. Standing orders/protocol for skin impairment are initiated. 3. Notify attending provider, resident, and resident representative. Attending provider determines wound type and may provide additional orders. 4. Notify Supervisor/designee. 5. Evaluate current pressure reduction interventions and revise resident centered care plan. 6. Notify dietitian for nutritional interventions. 7. Notify therapy associates and other members of the care team as appropriate for possible additional treatment interventions. 8. Educate resident/resident representative on skin impairment and care plan interventions. 9. When pressure injury is present, the dressing and/or wound as appropriate are monitored daily. 10. Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If wound bed has deteriorated; notify attending provider. 11. Notify the attending provider, resident/resident	F 686		

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F 686	Continued From page 14 representative, and supervisor if the skin injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, develop and implement safe smoking interventions to reduce the risk of avoidable injuries with tobacco products for 4 of 4 residents (R2, R4, R7 and R3), who smoked. These failures resulted in an immediate jeopardy (IJ) for R2 who was smoking unsupervised outside the doors of facility's attached assisted living (AL), caught fire, sustained burns to 90% of her body, and died as a result of her injuries. The IJ began on 2/1/24, when a recommendation from physical therapy identified R2 was not safe smoking independently unsupervised. The facility had not developed and implemented safe smoking interventions for R2 including but not limited to supervision. The administrator, director of nursing (DON), regional director of clinical services (RDCS)-A, Vice President of Clinical Services (VPCS)-A, Chief Operating Officer	F 689	Abatement Plan for Immediate Jeopardy F689 □ Accidents and Incidents Benedictine Living Shakopee- St. Gertrude□s, Shakopee, MN 02/08/2024 Interventions for identified residents: " Resident #2 expired in the hospital on 2/4. Medical Record was reviewed and sent to the Quality Assurance committee for process improvement opportunities. " Resident #3 was comprehensively assessed and deemed safe to smoke. Care plan was updated to reflect preferences and interventions offered to reduce the risk of accidents. " Resident #4 was comprehensively assessed and deemed safe to smoke. Care plan was updated to reflect preferences and interventions offered to reduce the risk of accidents.	3/13/24

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F 689	Continued From page 15 (COO)-A, and Vice President of Operations (VPO)-A were notified of the IJ for R2 on 2/8/24 at 12:41 p.m. The IJ was removed on 2/9/24 at 4:31 p.m. when an accepted removal plan was successfully implemented; however, non-compliance remained at an patterned scope with potential for more than minimal harm that is not immediate jeopardy (Level E). Findings include: Third degree burns penetrate the entire thickness of the skin and permanently destroy the tissue. These present a loss of layers, often painless (pain may be caused by patches of first- and second-degree burns surrounding the third-degree burns), and dry, leathery skin. Skin may appear charred or have patches that appear, white, brown, or black. The Saint Louis University Mental Status Exam (SLUMS)-a brief screening assessment used to detect cognitive impairment in adults over age 60. The SLUMS identified that a score of 27 to 30 means, normal in a person with a high school education; 21 to 26 mild neurocognitive disorder and 0 to 20 indicates dementia. Nursing Home Incident Report (NHIR) dated 2/4/24, identified an incident that the charge nurse was notified R2 had caught on fire while smoking. EMS notified. Facility staff and passerby had extinguished the fire. R2 was transferred to the hospital for treatment. According to the facility census line (undated) R2 had been in room 400 on 2/4/24. During a facility walk through observation on	F 689	" Resident #7 was comprehensively assessed and deemed safe to smoke. Care plan was updated to reflect preferences and interventions offered to reduce the risk of accidents. " Residents choosing to smoke will be assessed on admission and with any change in physical or cognitive function with a review and update of care plan interventions. Interventions for other residents at risk: " All other residents were reeducated that the facility is a non-smoking campus and should they choose to smoke while residing here, they should inform staff. No smoking materials were found in non-smoking resident rooms. Residents with Cognitive Impairment have had education provided to their representative that we are a non-smoking facility; material should not be left with the resident and if their smoking preference changes, they need to inform staff. Systemic Changes: " POL_AO010 Non Smoking - Tobacco Free Campus Policy Updated to reflect the protocol for residents choosing to smoke while residing on a non-smoking campus which includes a direct observation. " Smoking Observation has been updated to reflect our comprehensive and holistic approach which includes direct observation to determining safe smoking practices, which may include providing	

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F 689	Continued From page 16 2/7/24, at 10:52 a.m. a path was walked from the nursing home room 400 where R2 resided to the AL entrance (location of where R2 smoked and caught on fire). The total distance from R2's 400 room to the AL outside exit/entrance was approximately 155 steps. There was a AL receptionist desk located at the main entrance/exit of the AL. At 11:03 a.m. outside directly in front of the AL sliding glass double doors entrance/exit, approximately three feet from the door there was a scattered amount of black substance identified by the video footage viewed on 2/7/24 as the location of the fire for R2. There was not a cigarette receptacle in this area nor was one visible in the video footage on 2/4/24, the day of the fire. R2's Slums assessment dated 11/8/23, identified a score of 22 of 30 which indicated mild cognitive impairment. R2's admission Minimum Data Set (MDS) dated 1/24/24, identified R2 had intact cognition and diagnoses of left scapula fracture and essential tremor. R2 used a wheelchair for mobility; walking 10 feet from an uneven turf was not attempted due to medical condition or safety concern and did not identify if tobacco was used. R2's progress note dated 1/18/24 at 10:22 p.m., identified R2 as a current everyday cigarette smoker. R2's nurse practioner (NP) note dated 1/19/24 at 3:00 p.m., included a diagnosis of Tobacco abuse identifying R2 was a current one pack a day smoker and in the past had not been interested in quitting. Plan to add Nicotrol inhaler, counseled regarding smoking cessation.	F 689	interventions that promote safe smoking, resident education, asking residents to voluntarily surrender any smoking materials, and providing additional supervision (if residents who are assessed as unsafe still chose to leave campus to smoke). Education: " All staff will be educated on the updated Non Smoking - Tobacco Free Campus Policy. " All staff will be educated on reporting any signs indicative of a resident actively smoking or their choice to begin actively smoking and the need to immediately notify Nursing leadership. " All staff will be educated on actions to take if a resident is found smoking on campus which include immediate notification to supervisors and staff intervention to provide safety measures until the resident can be assessed for independence with smoking. " All staff will be educated on how to emergently extinguish fires, stop drop and roll, and the location and use of fire extinguishers and fire blankets. " Nursing leadership will be educated on the components of a safe smoking assessment, appropriate prevention strategies and care planning. " All staff will be educated on or before their next shift by in person education or email acknowledgement of understanding. " Residents, families, and other resident representatives will be educated about the updated no-smoking/tobacco-free campus policy,	

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F 689	Continued From page 17 R2's progress note dated 1/21/24 at 1:48 p.m., identified R2 had tremors and to monitor when R2 was outside/ensure return due to cold weather. R2's Safe Smoking Evaluation dated 1/21/24, completed by RN-C identified the date recorded was 1/21/24 at 9:11 p.m. and the evaluation was completed at 9:12 p.m. (1 minute) The form was an electronic document that prompted staff to evaluate and click on the appropriate predefined response; most response options to choose were 'Yes' or 'No'. The reason for assessment was marked as "Admission" The form identified the following. -Resident has been given education and information about smoking cessation; "Yes" was selected -Resident demonstrates an understanding of the smoking standards and policy; "Yes" was selected -Resident demonstrates ability to make own decisions; "Yes" was selected. -Resident demonstrates ability to hold cigarette/cigar/pipe safely; "No" was selected -Resident demonstrates ability to light the smoking material safely with lighter/match; "No" was selected. -Resident uses or verbalizes a willingness to use a flame-retardant smoking apron; "No" was selected -Resident appropriately uses an ash receptacle and does not drop ashes on self; "No" was selected -Resident demonstrates the ability to control holding the smoking material if bumped or distracted; "No" was selected. -Resident can safely extinguish the smoking material: "No" was selected	F 689	including the procedure for safe smoking behavior and the process if a resident chooses to smoke off-campus. Residents and representatives will be educated about not providing or sharing smoking materials to other residents. Compliance Date: 02/09/2024 This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F689: Free of Accident Hazards/Supervision/Devices CITED RESIDENT(S): R2 passed away at hospital on 02/04/2024. R3, R4, and R7 were comprehensively assessed and deemed safe to smoke independently off campus by Nursing Leadership. Care plan updated to reflect preferences and interventions offered to reduce the risk of accidents. Smoking aprons were offered and declined. Residents were educated that one is always available if requested. LIKE RESIDENT(S): All other like residents will be educated that the facility	

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F 689	Continued From page 18 -Resident complies with storage requirements for smoking material; "Yes" was selected. -Resident verbalizes and consents with understanding about not sharing smoking privileges with other residents "Yes" was selected. -Interdisciplinary Team (IDT) recommended resident to receive the following smoking status; (choices of selection included: Independent, Must be supervised, Smoking material must be secured, and Other) The only response selected was "Other-Resident is aware smoking is not prohibited on facility grounds. Resident chooses to decline nicotine patch and smoke in designated areas." The evaluation did not identify the reasons for the "No" selections, did not clearly identify if R2 was safe to smoke independently, and did not identify any education nor interventions provided for the boxes marked "No". R2's care plan dated 1/21/24, did not identify if R2 was safe to smoke independently nor safe smoking interventions if R2 chose to smoke. R2's care plan identified R2 had the potential for injury related by R2's choice to smoke. Interventions included: Ascertain resident wishes about smoking and respect residents decision, Evaluate for safety prior to smoking and screen per facility protocol, Instruct resident about smoking health effects on themselves and others, educate on risks and hazards, and provide resources for smoking cessation aides that are available. R2's vulnerable adult care plan dated 1/22/24, included "I am a vulnerable adult and need assistance to remain safe within the community. My admitting diagnosis is Laceration without foreign body of scalp, subsequent encounter."	F 689	is a non-smoking campus. If they choose to smoke while residing here, they should inform staff and follow process below. No smoking materials were found in non-smoking resident rooms. Residents with Cognitive Impairment have had education provided to their representative that we are non-smoking facility; material should not be left with the resident and if their smoking preference changes, they need to inform staff. Nursing Leadership will complete a smoking assessment. If Resident is deemed safe to smoke, care plan will be updated with interventions that promote safe smoking. In addition to Resident being deemed safe to smoke, Nursing orders will be added to treatment record for Nursing Staff to monitor Resident post smoking activity for any burns on hands, and any burn holes in clothing. If any abnormalities are noted, Nursing Staff will immediately notify DON/Administrator as a new smoking assessment would need to be completed to determine if Resident remains safe to smoke. If Resident is deemed unsafe to smoke, the Non-Smoking Tobacco Free Campus Policy will be followed. In addition, any clothing with burn holes noted will be removed out of circulation. If Resident is deemed safe to smoke, Nursing orders to be added to treatment record. EDUCATION: Non-Smoking Tobacco Free Campus Policy has been updated. All staff have been educated on the updated Non-Smoking Tobacco Free Campus Policy. All staff have been	

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F 689	Continued From page 19 In review of R2's record it was not evident R2 was provided/educated on the risk and benefits of smoking off campus independently, and instructions/interventions on what to do in the event of an emergent situation that required assistance even though R2's care plan informed staff R2 was at risk for injury and was vulnerable because she required assistance. During an interview on 2/7/24 at 9:37 a.m., registered nurse (RN)-C stated residents have the right to smoke at the facility but there was not a designated area for residents to smoke because the facility was non-smoking. The residents must go off campus to smoke (outside the AL) and needed to be able to smoke independently; the facility did not provide supervision. When a resident who smoked was admitted to the facility nursing would complete a smoking evaluation to determine if the resident was safe to smoke independently. The evaluation questions were reviewed with the smoking resident. RN-C would then watch the resident smoke to determine if they were safe. If the resident was determined to be an unsafe smoker RN-C would notify the administrator and the DON of the issue. Smoking supplies would be removed from the resident's possession with discussion and removal of supplies would be documented in the progress notes. A resident that would continue to smoke would be educated on a cessation program and the social worker and family would be included in those conversations. The clinical nurse manager would provide education to residents upon admission and when staff reported concerns of smokers who were not smoking in the right area. R2's smoking evaluation was done in January and the evaluation demonstrated that R2 was not safe to	F 689	educated on reporting any signs indicative of a resident actively smoking or their choice to begin actively smoking and the need to immediately notify Nursing Leadership. All staff have been educated on actions to take if a resident is found smoking on campus which include immediate notification to supervisors and staff intervention to provide safety measures until the resident can be assessed for independence with smoking. All staff have been educated on how to emergently extinguish fires, stop drop and roll, and the location and use of fire extinguishers and fire blankets. All new hires and PRN agency staff will be educated prior to working their first shift. Nursing leadership have been educated on the components of a safe smoking assessment, appropriate prevention strategies and care planning as Nursing Leadership will be responsible for completing admission, readmission, quarterly, annually, and significant change smoking assessments. Residents choosing to smoke will be assessed by Nursing Leadership on admission and with any change in physical or cognitive function with a review and update of care plan interventions. Education will be reiterated at all staff meetings on March 8th, 2024. AUDITS: DON or designee will audit current smokers to verify adherence to the smoking policy by direct observation weekly x 4 weeks and monthly x 3 months. Campus Administrator, DON or designee will audit staff to verify	

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F 689	Continued From page 20 smoke. RN-C stated that R2 was not visualized smoking for the smoking assessment. RN-C had previously visualized R2 smoking prior to nursing home admission when R2 resided at the attached AL. RN-C stated R2's family was aware R2 smoked however, was not sure if the family was made aware R2 was deemed unsafe to smoke after the assessment was completed. Further not aware if it was communicated to family member (FM)-A that R2 would not be supervised while smoking because the facility was non-smoking. R2's progress note dated 1/22/24 at 11:20 a.m., identified R2 telling unknown nursing assistant "I am going outside to smoke." At 11:25 a.m., identified R2 stating "I was disoriented. Didn't know where I was or what I was doing.", regarding a fall that occurred on 1/22/24. At 12:55 p.m., R2 had tremors, and safety precautions to monitor when patient outside/ensure return due to cold weather. Subsequent notes on 1/22/24 between 3:07 p.m. and 3:14 p.m. indicated Nicotrol (a nicotine replacement medication used to stop smoking) was not available, and the NP was notified. R2's Occupational Therapy (OT) treatment encounter note dated 1/23/24, identified R2 was 15 minutes late to treatment due to being outside smoking. SLUMS score was a 21/30 indicating mild cognitive impairment. R2's NP note dated 1/23/24, identified R2 continued to smoke outside and was counseled regarding smoking cessation. Nicotrol inhaler ordered, supply has not arrived from pharmacy. R2 had used Chantix (medication used to stop smoking that does not contain nicotine) in the past was ineffective and caused nausea. Plan for	F 689	understanding of the above education weekly x 4 weeks and monthly x 3 months. Audit results will be reviewed by Quality Council monthly for further actions if needed. Any Resident deemed unsafe to smoke through smoking assessment and direct observation conducted by Nursing Leadership, the facility will follow Non-Smoking Tobacco Free Campus Policy. If Resident is deemed unsafe to smoke or not complying with safe smoking rules, Resident may have smoking materials removed or asked to give them up. Residents will be offered smoking cessation options which include, but are not limited to the following; nicotine patch, nicotine gum, nicotine inhaler, and Chantix. Per Non-Smoking Tobacco Free Campus Policy, Resident may be provided equipment to aide in safety (such as a smoking apron) when they choose to smoke while off campus. In addition, the community staff will consult with resident and/or resident representative for alternate assistance to use off campus smoking options, if assessed.	

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F 689	Continued From page 21 Nicotrol inhaler (small hand-held inhalation device that contains nicotine cartridges) and R2 was counseled regarding smoking cessation, if Nicotrol inhaler ineffective would start Chantix along with Zofran for nausea. R2's progress note dated 1/24/24 at 3:54 p.m., identified R2 still smoked and would leave the unit without telling staff. R2's progress note dated 1/26/24 at 12:46 p.m., identified based on balance testing R2 was a high risk for falls and SLUMS 21/30. R2's OT treatment encounter note dated 1/26/24 at 3:25 p.m., identified care conference were held with R2, R2's family members, facility director and assisted living manager. Discussed safety with activities of daily living (ADL's) and falls. Notes had no mention of smoking status addressed or concerns with R1 smoking. R2's Associated Clinic of Psychology (ACP) note with a service date of 1/26/24, identified R2 with adjustment disorders and mixed disturbance of emotions and conduct. Within the mental status exam identified that R2 presented with probable reduced insight and judgement along with SLUMS subtest which indicated moderate cognitive impairment. R2 presented with deficits in calculation, executive functioning, and short-term memory. R2 stated to be a current every day smoker and had been counseled to quit. R2's progress note dated 1/28/24 at 11:03 a.m., identified R2 was still smoking and started on Chantix. Does leave unit to go smoking and to AL apartment-during the daytime.	F 689		

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F 689	Continued From page 22 R2's physical therapy (PT) treatment encounter note dated 1/29/24 at 1:15 p.m., identified R2 not in room at scheduled therapy time due to being outside smoking. R2's progress notes dated 1/29/24, identified R2 as a current smoker, was on Chantix medication-day three and R2 was planning to go outside to smoke after moving to new room (in the nursing home). Review of R2's January and February 2024 medication administration (MAR) identified the prescribed medications that had the potential to help R2 quit smoking were not administered as prescribed: - Chantix: According January/February MAR identified Chantix start date of 1/27/23. R2 was administered Chantix 0.5 mg per physician order on 1/27/24, 1/28/24, and 1/29/24. Starting on 1/30/24, R2 was supposed receive 0.5 mg twice a day. The MAR identified R2 did not receive evening doses on 1/31/24, 2/1/24, 2/3/24, and neither doses were administered on 2/4/24. The dose on 2/3/24, note identified R2 "did not want to take." -Nicotrol inhaler: January/February 2024 MAR identified Nicotrol (nicotine) cartridge; 10 milligrams (mg) give every two hours as needed; puff for 20 minutes per cartridge. Nicotrol inhaler was not administered between 1/19/23 to 1/23/24. Corresponding nursing notes from 1/19/24 to 1/22/24 identified the medication was not given because the medication was not available. -Nicotrol nasal spray: January/February MAR identified Nicotrol nasal spray non-aerosol; 10 mg/milliliter (ml) give a spray to nostril every hour	F 689		

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F 689	Continued From page 23 as needed may repeat one spray if not effective. The MAR identified Nicotrol spray was never administered. R2's OT treatment encounter note dated 1/31/24, identified OT attempted therapy three times that afternoon and each time R2 was out of the building smoking. Undated Facility eSource document indicated the administrator identified a concern on 1/31/24 at 4:20 p.m., R2 was smoking on facility grounds. Expectations/desired outcome as R2 was to not smoke on a non-smoking campus. R2's progress note dated 1/31/24 at 9:21 p.m., identified staff stated R2 was not safe to smoke outside by self. R2 replied that her mind was intact, and she can go outside and smoke on her own. R2's progress note dated 2/1/24 at 1:04 p.m., authored by the DON included "Resident was outside smoking and self-propelling backwards in wheelchair into building." Resident indicated she has been smoking and not cutting back. "Educated resident on smoking with Chantix and safe smoking practices/non-smoking campus." Resident verbalized understanding at the time of the conversation. (staff name) updated and indicated that family was bringing in cigarettes and was going to stop moving forward to assist in supporting resident with cessation. R2's record does not define/specify which "safe smoking practices" were provided. R2's PT discharge summary note dated 2/1/24, identified R2 as a smoker and would go outside in wheelchair very often to smoke. A	F 689		

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recommendation for R2 to a LTC (long term care) placement that allows smoking somewhere right outside the door so R2 can be supervised and in a safe location.

R2's OT discharge summary note dated 2/1/24 identified R2 has limitations due to safety and recommendation for higher level of care and monitoring, recommend assist with all ADLs.

During an interview on 2/8/24 at 7:36 a.m., physical therapist (PT)-A indicated R2 had been on their patient load several times. PT-A identified R2 was an avid smoker, did not want to quit smoking, and continued to smoke throughout R2's stay. PT-A stated R2 was not safe to be in the community independently, this was why R2 was moved from her assisted living to long term care. R2 kept falling and hurting herself, this last time R2 had a huge laceration to the side of the head requiring several stitches. PT-A stated, "[R2] was not necessarily demented, but made terrible choices, did not care about safety and was very impulsive." R2 was a danger to herself and needed more supervision, we tried to provide that. When R2's cigarette supplies were taken away, she somehow kept getting more. "We have been trying to prevent [R2] from smoking because it was absolutely not safe for her to be doing it on her own." Physical therapy assistant (PTA)-A stated "[R2] was at least a pack a day smoker." PTA-A further indicated R2 missed a few days of therapy due to smoking. PTA-A indicated visualizing cigarette burns on R2's clothing on several different occasions.

Undated Facility eSource document indicated the administrator identified a concern on 2/2/24 at 1:00 p.m., R2 was smoking on a non-smoking

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F 689	Continued From page 25 campus. Assisted living clinical manager noted R2 to be smoking on facility grounds, was re-educated, and told R2 to not smoke. DON confiscated R2's smoking materials. During an interview on 2/7/24 at 2:06 p.m., trained medication aide (TMA)-A indicated if a resident smoked it would be on the care plan. Residents kept smoking materials on them and should "sign out" at the front desk by the AL entrance when they go out to smoke. Staff did not supervise residents who smoked nor check for burns on their body or clothing after the resident got done smoking. TMA-A was not able to articulate how residents would communicate or notify staff if they needed help outside without staff. During an interview on 2/7/24 at 2:12 p.m., nursing assistant (NA)-B stated staff did not check residents that smoked for holes burned into clothing or body parts after they were done smoking. Residents that smoke without supervision had no way to alert staff if they needed help. During an interview on 2/7/24 at 3:23 p.m., NA-A identified R2 was known to go out and smoke. NA-A would see R2 outside smoking, but staff did not have to go outside with her. During an observation on 2/7/24 at 3:25 p.m., R2 had two clear plastic bags labeled with name in a closet in the room where R2 resided. A size large blue Columbia half zip fleece pullover with no hood was in the bag. The pullover contained a burn mark located by the left breast area zipper, two burn holes on the left sleeve and a burn hole on the cuff of the sleeve.	F 689		

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F 689	Continued From page 26 During an interview on 2/7/24 at 3:33 p.m., licensed practical nurse (LPN)-B stated R2 was a smoker and used to see R2 outside smoking but never with any staff. LPN-B was unable to articulate safety interventions or protocols for residents who were determined unsafe to smoke but smoked without supervision. During an interview on 2/8/24 at 8:17 a.m., receptionist (R)-A stated "[R2] smoked a lot" since admission and would smoke at the front entrance without any staff supervision. R2 always wore a long dark jacket and had noticed burn holes in the fur hood of R2's jacket. During an interview on 2/8/24 at 8:23 a.m., RN-A indicated working the day shift on 2/4/24, R2 would usually smoke out of the transitional care unit (TCU) entrance and was not aware if R2 needed supervision to smoke. RN-A had never checked R2 for burns on her clothing or body after she came in from outside. Even though R2's record identified R2 was not safe to smoke, the record had multiple documented occurrences on 1/22/24, 1/23/24, 1/24/24, 1/28/24, 1/29/24, 1/31/24, and 2/1/24 of staff's awareness of R2's plan to go outside to smoke and/or was witnessed by staff outside smoking. There was not indication the facility identified any immediate safety interventions implemented for R2. Nor does the record identify documentation of assessments completed after smoking for burn holes on clothing. . During an interview on 2/7/24 at 3:25 p.m., NA-C stated on 2/4/23, at approximately 5:30 p.m. R2 was in her room standing near the bed putting her	F 689		

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jacket on. NA-C reported no direction had ever been given to supervise R2 when smoking. NA-C stated unawareness of monitoring skin or clothing after smoking.

R2's progress note dated 2/4/24 at 6:30 p.m., identified "was updated that R2 noted to have an incident related to smoking causing burns. Nursing staff immediately responded, 911 was called by nursing staff. R2 was transferred to hospital emergency room (ER) via ambulance. NP and family updated."

During a return phone interview on 2/15/24 at 1:50 p.m., NA-D who was working at the time of the incident stated that on 2/4/24, he was working on the 200 hallway and had been near the dining room when he saw and heard an unidentified visitor come around the corner yelling "come, come, fire, fire!". The unidentified visitor told him the fire was outside. NA-D then went outside the AL door to find R2 on fire, "the fire was huge." NA-D ran back inside passing two nurses who went outside. NA-D stated he then grabbed the fire extinguisher and handed it to someone else and let them put the fire out.

During an interview on 2/8/24 at 3:40 p.m., LPN-A identified she worked the evening of 2/4/24 as the charge nurse of the building. LPN-A stated around 5:30 p.m. R2 had finished eating and was noted to be having urinary tract infection symptoms. R2 always wore a jacket with the furry hood that had a quarter sized burn hole on the lower part of her jacket and a dime sized burn whole near the front chest of the jacket. R2 was a known frequent smoker; she would go out and smoke at least twice a shift. LPN-A's recollection of events were, "I heard a male voice yelling Fire,

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Fire, Fire! so I was walking near the fire doors, he said help help help she is on fire. I followed the sound of the man's voice and it was out the AL doors." LPN-A stated she saw R2 outside the doors about three feet from the building seated in the wheelchair and R2 was completely engulfed in flames." LPN-A looked for the fire extinguisher but could not see through all the smoke. LPN-A grabbed a half pitcher of water located on the medication cart, grabbed a blanket, and ran back outside. RN-B dumped the water on R2 and someone "started hitting [R2] with the blanket" and "That's when the flames went way above R2's head." LPN-A stated she "told an aide to call 911" and RN-B used the fire extinguisher to put the fire out. The paramedic asked R2 to state their name and R2 responded in a very soft voice, her name and answered yes to having pain.

Review of the facility video footage of 2/4/24, identified at 6:00 p.m. R2 had wheeled self out of the automatic double doors of the AL entrance and stopped approximately three feet from the building and lit a cigarette, no cigarette receptacle was observed. R2 was not wearing oxygen nor was there an oxygen tank on or around her wheelchair. R2 wore a dark long jacket that was unzipped with a hood brimmed with long fur. Between 6:00 p.m and 6:07 p.m. R2 can be seen intermittently leaning forward in her wheelchair so that her head was half way to her knees while she continued to smoke. At 6:07 p.m. R2's jacket on the left side was visualized to be on fire (either the bottom of her coat or the cuff of her coat), R2 stood up, and attempted to remove jacket, R2 removed right jacket sleeve at 6:08 p.m. 15 seconds later R2's shirt caught on fire, about 20 seconds later R2 threw the jacket on the ground and R2's legs caught on fire, R2 fell back into the

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F 689	Continued From page 29 wheelchair. At 6:09 p.m. R2's left arm was also on fire, R2's head/shoulders were engulfed in flames by 6:10 p.m. An elderly unknown male came out of the facility at 6:10 p.m. and attempted to move R2's wheelchair without success and then went back into the facility. R2 stood up again, her feet were engulfed in flames. At 6:10 p.m. and 54 seconds an unknown facility male staff came out of the facility looked at R2 and went back in the facility. Then another unknown facility male staff came out of the door and tried to remove clothing off of R2, staff came out with a blanket and put the blanket around R2's left side without smothering the flames while the other male staff member vigorously and rapidly moved blanket up and down over in a fanning motion which seemed to increase the flames. Shortly after a pitcher of water was thrown on R2. At 6:12 p.m. a fire extinguisher was activated within two feet and sprayed directly at R2 (ABC fire extinguisher-an extinguisher that uses a powder chemical to extinguish a fire). The fire was extinguished at 6:12 p.m. and 27 seconds. Emergency medical services (EMS) attended to R2 at 6:15 p.m. R2 was engulfed in flames from 6:07 p.m. to 6:12 p.m. for almost a full 5 minutes. During a phone interview on 2/14/24 at 1:39 p.m., investigations sergeant (IS)-A indicated they reviewed the facility video from 2/4/24. IS-A stated R2 was unsupervised had wheeled self out the doors and was smoking a cigarette when R2's clothing caught on fire. "R2 was on fire for almost a full five minutes and was completely engulfed in flames, the whole facility could have gone up in flames." IS-A stated this was completely preventable, it would have been so easy to help R2, all the facility had to do was provide adequate	F 689		

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F 689	Continued From page 30 supervision. The Shakopee Police Department Incident Report dated 2/4/24, identified officers arrived on the scene at 6:13 p.m., identified and recorded statements from six members of the police department that were on scene. Statements indicated that R2 was no longer on fire but appeared that R2 had been fully engulfed in flames at one point, a nurse was holding R2 in what remained of the frame of the wheelchair that the fire had disintegrated the padding. R2's legs were caught inside the chair. R2's clothing was all burnt off and personal items on the ground near R2 included shoes, glasses, keys, one blanket, one sheet, a cell phone, empty cigarette boxes and cigarettes. R2 was assisted out of the wheelchair and onto a blanket. Investigation showed that R2 was a smoker and often went outside in that area to smoke cigarettes. During a phone interview on 2/13/24 at 2:38 p.m., police officer (PO)-A indicated being called to the facility on 2/4/24 sometime after 6:00 p.m. R2 was naked, body covered in burns seated in a wheelchair, the seat had melted away. PO-A stated RN-B reported to her R2 had been smoking for quite some time, R2 had snuck out of the building to smoke, and staff did not provide supervision to the residents that smoked. PO-A stated, "R2 was helpless seated in the wheelchair and literally started on fire, someone should have noticed R2 went out, this would have been completely preventable." The hospital Health Emergency Medical Services (EMS) document dated 2/4/24, identified ambulance arrived on scene, 2/4/24 at 6:18 p.m., R2 had third degree burns over 70% of body, full	F 689		

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F 689	Continued From page 31 thickness burns from mid thighs down to feet. R2 had soot and burns and the dry chemical from fire extinguisher in nares (nostrils) and mouth and arrived at the hospital at 6:43 p.m. R2's Healthcare Burn Unit Emergency Department (ED) provider note dated 2/4/24, identified R2 had deep third degree burns to 90% of the body with the only area spared being the right upper back. Injuries reported were suspected from R2 smoking at the time. Proximate cause of death was full thickness burns and immediate cardiopulmonary arrest (sudden loss of all heart activity). During a phone interview on 2/12/24 at 3:42 p.m., family member (FM)-A explained R2 was living at the AL building but was not safe to be there unsupervised and needed a nursing home. R2 had a long history of hand tremors that would cause her to occasionally drop lit cigarettes that would cause burns on her hands and clothing. R2 also had a history of falling asleep while smoking cigarettes and has had several falls. FM-A thought R2 would be much safer at the nursing home because she would have increased supervision. FM-A explained R2 had historically successfully quit smoking using a Nicotrol inhaler. Upon admit to the LTC facility R2 had been offered Nicotrol inhaler, but it never showed up. FM-A stated R2 called her during the day of 2/4/24, her words were slurred. FM-A thought something was not right. During the call R2 asked FM-A "can I smoke if I get off the Chantix?" FM-A stated she told R2 "to not smoke because the facility did not want her smoking." FM-A was crying as she recalled the first call she received about the fire on 2/4/24. FM-A stated the hospital called her before the facility. The hospital told	F 689		

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ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET SHAKOPEE, MN 55379

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F 689	Continued From page 32 FM-A that R2 had sustained burns that covered 85%-90% of her body and it was not survivable. When FM-A arrived at the hospital to say good-bye to R2. She was in the hospital elevator when she received a call from the DON and administrator. They told her R2 had gotten a hold of cigarettes and "started a little fire," that was put out within 60 seconds, and R2 was sent to the hospital. "They made it sound like no big deal! Had the hospital not called me I would have gone to bed and dealt with it in the morning." FM-A asked the facility for more details but no one would tell her. FM-A stated, "I just want to know that [R2] didn't suffer!" FM-A continued to cry as she identified what she saw when entering (R2's) hospital room. R2's hair was singed, her face was blackened. The doctor told her she did not want to see what was under the bandages, R2 died that night. FM-A stated R2's friend who smoked with (R2) over at the AL informed her that after R2's accident. R2 had been leaning to one side for a couple of days prior to the incident. FM-A thought in looking back, she questioned if R2 had a stroke. R2's friend also informed FM-A that she was offered a smoking apron. FM-A stated that was never offered to (R2), "why didn't the facility offer [R2] a smoking apron!?" FM-A stated the facility had never offered an apron to her and had never seen any residents with smoking aprons. "A smoking apron would have saved [R2's] life, [R2] never should have died like that." During an interview on 2/7/24 at 4:07 p.m., Administrator and director of nursing (DON) both identified the facility as a "non-smoking campus; residents who smoked, must smoke off-campus on the sidewalk in front of the building." DON further identified if a resident was deemed to be an unsafe smoker, then nicotine replacement was	F 689		

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F 689	Continued From page 33 offered, resident's smoking material were removed, family would be involved to help the resident quit, and IDT involvement. DON indicated R2 was a smoker prior to admission and R2 continued to smoke during her stay, however R2 had never been observed smoking from start to finish as part of the smoking assessment to determine level of risk or necessary safety interventions. DON expected observations and a smoking evaluation to be completed with an active smoker on admission, quarterly and with a significant change as part of the smoking assessment. DON and administrator stated the facility's strategies to keep R2 safe included: the physician ordered nicotine replacement on 1/19/24, but was never available due to a pharmacy issue. On 1/26/24, physician ordered Chantix to help stop smoking. On 1/29/24, R2 was deemed unsafe to smoke outside due to R2 not physically able to wheel herself back into the facility. Additionally on 1/31/24, R2's smoking materials were taken away. On 2/1/24, and 2/2/24, R2's smoking materials were again removed when R2 was found smoking on facility ground. R2 was also re-educated of the smoke free campus, the physician was notified, and a discussion with family who agreed not to provide R2 with smoking materials. DON indicated after the incident on 2/4/24, she came to the facility to reassess R3, R4, and R7. DON stated she completed the assessments by watching the residents smoke from the doorway of the gardens inside the facility. This was approximately 30-35 yards away from the designated smoking area. DON stated based on the assessments all three residents were deemed safe to smoke. The DON offered them smoking	F 689		

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F 689	Continued From page 34 aprons and were re-educated on the need to sign out in the book to go out and smoke off campus. The administrator stated, we are a non-smoking facility, and residents need to be off campus to smoke. If residents were deemed unsafe to smoke, education is provided, smoking supplies are removed, and a discussion with family. When a resident signs out to go off campus the resident was assuming responsibility we are not here to oversee and supervise them. Sign out sheets to go off campus for R2 were requested and never received. During an interview on 2/8/24 at 9:56 a.m., the administrator stated they had completed the investigation for R2. The administrator stated, "the root cause of R2's accident was noncompliance with R2 making a poor decision." R4's undated face sheet identified R4 had diagnoses of nicotine dependence, epilepsy with status epilepticus , diabetes, difficulty in walking, muscle weakness, and long term use of anticoagulants. R4's quarterly MDS assessment dated 11/22/23, identified R4 to have moderate cognitive impairment and used a walker independently with walking. R4's care plan dated 4/24/23, identified a behavior problem with the potential for injury related to R4's choice to smoke. Interventions were to notify the clinical manager immediately if it is suspected resident had violated smoking rules and support resident with smoking cessation in collaboration with the attending	F 689		

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F 689	Continued From page 35 physician if the resident decides to stop smoking. R4's vulnerable adult care plan dated 12/6/23, included "I am a vulnerable adult and need assistance to remain safe within the community. My vulnerabilities include vulnerable to abuse from others." R4's Safe Smoking Evaluation Dated 1/14/24, completed by the DON identified the date recorded was 1/14/24 at 9:46 p.m. and the evaluation was completed at 9:48 p.m. The form was an electronic document that prompted staff to evaluate and click on the appropriate predefined response; most response options to choose were 'Yes' or 'No'. The reason for assessment was marked as "Annual" The form identified the following. -Resident has been given education and information about smoking cessation; "Yes" was selected -Resident demonstrates an understanding of the smoking standards and policy; "Yes" was selected -Resident demonstrates ability to make own decisions; "Yes" was selected. -Resident demonstrates ability to hold cigarette/cigar/pipe safely; "No" was selected -Resident demonstrates ability to light the smoking material safely with lighter/match; "No" was selected. -Resident uses or verbalizes a willingness to use a flame retardant smoking apron; "No" was selected -Resident appropriately uses an ash receptacle and does not drop ashes on self; "No" was selected -Resident demonstrates the ability to control holding the smoking material if bumped or distracted; "No" was selected.	F 689		

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F 689	Continued From page 36 -Resident can safely extinguish the smoking material: "No" was selected -Resident complies with storage requirements for smoking material; "No" was selected. -Resident verbalizes and consents with understanding about not sharing smoking privileges with other residents "No" was selected. -IDT recommends resident receive the following smoking status; (choices included: Independent, Must be supervised, Smoking material must be secured, and Other) The only response selected was "Other-Resident is aware smoking is "not prohibited on facility grounds"" The evaluation did not identify the reasons for the "No" selections, did not clearly identify if R4 was safe to smoke independently, and did not identify any education nor interventions provided for the boxes marked "No". R4's Safe Smoking Evaluation form dated 2/4/24, was completed by the DON, identified the date recorded was 2/4/24 at 10:40 p.m. and the evaluation was completed at 10:43 p.m. The form had the same questions as the eval dated 1/14/24. The form identified the reason for assessment was "Re-Education" but did not specify the reason and/or what education was provided. All of the responses to the questions were marked "Yes" except for Resident uses or verbalizes a willingness to use flame retardant apron; "No" was selected. "Other-Resident is aware smoking is "not prohibited on facility grounds"" was again selected in response to IDT recommends resident receive the following smoking status. The evaluation did not clearly identify if R4 was safe to smoke independently, and did not identify any education nor interventions provided for the boxes marked "No".	F 689		

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F 689	Continued From page 37 R4's Non-Smoking Campus education document that was signed and dated by R4 and the DON on 2/4/24, included St. Gertrude's and the Garden's is a smoke free facility and campus. Resident verbalizes understanding standards and facility policy. Resident has been given education and information about smoking cessation. Resident verbalizes and consents with understanding about not sharing smoking materials with other residents. R4's progress note dated 2/4/24 at 10:43 p.m. authored by the DON included Resident was re-educated on the facility being a smoke free campus. Resident verbalized understanding of smoking standards and facility policy. Writer did offer a smoking apron in the event resident choose to go out and smoke and resident denied. Resident given re-education and information on smoking cessation. Resident verbalizes understanding and consents with understanding about not sharing smoking materials with other residents. R4's care plan was revised on 2/4/24, added the interventions that notified staff R4 denied the use of smoking apron, but was aware one was available. In review of R4's record it was not evident R4 was provided/educated on the risk and benefits of using a smoking apron, smoking off campus independently, and instructions/interventions on what to do in the event of an emergent situation that required assistance even though R4 was at risk for injury according to her care plan dated 4/24/23.	F 689		

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F 689	Continued From page 38 During an observation and interview on 2/7/24 at 1:39 p.m., R4 was on the sidewalk by the AL with a lit Old Gold brand cigarette. R4 was standing and hanging on to the handles of a four wheeled seated walker. The brakes were not engaged on the walker. R4 wore a long, black winter jacket that went to the knees and was zipped, no glove use noted. R4 indicated cigarette usage was 4-5 cigarettes per day and the smoking supplies were kept in the purse. R4 stated that staff have never went outside and observed a smoking session. When the weather was bad, all of the smokers smoked under the AL canopy. R4 stated that since R2 had a burn incident the staff make them sign out to smoke. R4 removed a plastic pop container filled with cigarette butts and a dark brown liquid from a purse. R4 sat without engaging the brakes on the walker, the cigarette hanging out of her mouth had a long chain of ash burning (approximately 2/3 of the cigarette) as R4 had not discarded any ashes from the lit cigarette and with the cigarette hanging out of her mouth she rotated 180 degrees to sit on the walker as the ashes fell to the ground. R4 proceeded to smoke the cigarette down to the filter, unscrewed the lid from the pop bottle, dropped the still burning cigarette filter into the pop bottle without extinguishing it and screwed the lid back on the pop bottle. R4 then placed the plastic bottle inside her purse. R4 indicated she always used the pop bottle for her cigarette butts. R4 stated there was no way to notify the staff for help while outside. R7's quarterly MDS assessment dated 11/7/23, R7 to have intact cognition and diagnoses of diabetes, anxiety, depression and tobacco abuse. R7 used a walker and wheelchair for mobility. Current tobacco use was not assessed.	F 689		

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F 689	Continued From page 39 R7's care plan dated 5/18/23, identified a behavior problem with the potential for injury related to R7's choice to smoke and interventions were to notify the clinical manager immediately if it is suspected resident had violated smoking rules and support resident with smoking cessation in collaboration with the attending physician if the resident decides to stop smoking. R7's vulnerable adult care plan dated 11/20/23, included I am vulnerable adult and need assistance to remain safe within the community. My vulnerabilities include but not limited to: vulnerable to abuse from others, at risk for abusing others, anxiety, opioid dependence and depression. R7's Safe Smoking Evaluation Dated 1/14/24, completed by the DON identified the date recorded was 1/14/24 at 9:52 p.m. and the evaluation was completed at 9:53 p.m. The form was an electronic document that prompted staff to evaluate and click on the appropriate predefined response; most response options to choose were 'Yes' or 'No'. The reason for assessment was marked as "Annual" The form identified the following. -Resident has been given education and information about smoking cessation; "Yes" was selected -Resident demonstrates an understanding of the smoking standards and policy; "Yes" was selected -Resident demonstrates ability to make own decisions; "Yes" was selected. -Resident demonstrates ability to hold cigarette/cigar/pipe safely; "No" was selected -Resident demonstrates ability to light the smoking material safely with lighter/match; "No"	F 689		

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F 689	Continued From page 40 was selected. -Resident uses or verbalizes a willingness to use a flame retardant smoking apron; "No" was selected -Resident appropriately uses an ash receptacle and does not drop ashes on self; "No" was selected -Resident demonstrates the ability to control holding the smoking material if bumped or distracted; "No" was selected. -Resident can safely extinguish the smoking material: "No" was selected -Resident complies with storage requirements for smoking material; "No" was selected. -Resident verbalizes and consents with understanding about not sharing smoking privileges with other residents "No" was selected. -IDT recommends resident receive the following smoking status; (choices included: Independent, Must be supervised, Smoking material must be secured, and Other) The only response selected was "Other-Resident is aware that facility policy is no smoking on facility grounds." The evaluation did not identify the reasons for the "No" selections, did not clearly identify if R7 was safe to smoke independently, and did not identify any education nor interventions provided for the boxes marked "No". R7's Safe Smoking Evaluation form dated 2/4/24, was completed by the DON, identified the date recorded was 2/4/24 at 10:33 p.m. and the evaluation was completed at 10:34 p.m., one minute later The form had the same questions as the eval dated 1/14/24. The form identified the reason for assessment was "Re-Education" but did not specify the reason and/or what education was provided. All of the responses to the questions were marked "Yes" except for Resident	F 689		

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F 689	Continued From page 41 uses or verbalizes a willingness to use flame retardant apron; "No" was selected. "Other-Resident is aware facility policy is no smoking on facility grounds,"was again selected in response to IDT recommends resident receive the following smoking status. The evaluation did not clearly identify if R7 was safe to smoke independently, and did not identify any education nor for interventions provided for the boxes marked "No". During an interview on 2/7/24 at 2:48 p.m., R7 was noted to walk out of his room using a wheeled walker. R7 stated, "I am more of a night owl and like to smoke in the middle of the night, no nurse here has ever watched me smoke a cigarette." During an interview on 2/7/24, at 2:19 p.m., interim Clinical Manager (CM)-A stated upon notification that a resident smoked, a comprehensive smoking assessment was completed. The assessment included an observation of the resident smoking including safe storage of smoking materials, lighting the cigarette, appropriate ashing, extinguishing the cigarette and ability to place the butt in an appropriate receptacle. In addition, the resident's cognition and dexterity were also considered to determine safety. CM-A identified two residents who smoked, R4 and R 7 were both safe to smoke unsupervised. Residents keep their own cigarettes and lighter on them. If a resident who was not safe to smoke went outside, then staff would have to provide supervision to keep them safe. CM-A was unable to articulate how a resident would alert staff if they needed help while outside smoking without supervision.	F 689		

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F 689	Continued From page 42 R3's admission MDS dated 1/15/24, identified R3 to have intact cognition and diagnoses of cellulitis of left lower limb, dialysis dependent, difficulty walking, muscle weakness, and nicotine dependence. R3 used a walker and wheelchair for mobility. Walking 10 feet from uneven turf was not attempted due to medical condition or safety concern and currently used tobacco. R3's care plan dated 12/30/23, identified a safety problem with the potential for injury related to R3's choice to smoke. Interventions were to notify the clinical manager immediately if it is suspected resident had violated smoking rules and support resident with smoking cessation in collaboration with the attending physician if the resident decides to stop smoking. R3's vulnerable adult care plan included "I am a vulnerable adult related to resident in a skilled nursing facility, stated medical diagnoses, and dependent on others for cares." R3's Safe Smoking Evaluation dated 1/4/24, completed by RN-C identified the date recorded was 1/4/24 at 6:44 a.m. and the evaluation was completed at 6:47 a.m., three minutes later. The form was an electronic document that prompted staff to evaluate and click on the appropriate predefined response; most response options to choose were 'Yes' or 'No'. The reason for assessment was marked as "Admission" The form identified the following. -Resident has been given education and information about smoking cessation; "Yes" was selected -Resident demonstrates an understanding of the smoking standards and policy; "Yes" was selected	F 689		

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F 689	Continued From page 43 -Resident demonstrates ability to make own decisions; "Yes" was selected. -Resident demonstrates ability to hold cigarette/cigar/pipe safely; "No" was selected -Resident demonstrates ability to light the smoking material safely with lighter/match; "No" was selected. -Resident uses or verbalizes a willingness to use a flame-retardant smoking apron; "No" was selected -Resident appropriately uses an ash receptacle and does not drop ashes on self; "No" was selected -Resident demonstrates the ability to control holding the smoking material if bumped or distracted; "No" was selected. -Resident can safely extinguish the smoking material: "No" was selected -Resident complies with storage requirements for smoking material; "No" was selected. -Resident verbalizes and consents with understanding about not sharing smoking privileges with other residents "No" was selected. -IDT recommended resident receive the following smoking status; (choices of selection included: Independent, Must be supervised, Smoking material must be secured, and Other) The only response selected was "Other- patient agrees not to smoke while at facility." The evaluation did not identify the reasons for the "No" selections, did not clearly identify if R3 was safe to smoke independently, and did not identify any education nor interventions provided for the boxes marked "No". R3's late entry progress note dated 1/26/24 for 1/25/24 at 3:36 p.m., indicated a nurse went to meet with R3 "but was not in her room. Found patient sitting by TCU door on bench outside	F 689		

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F 689	Continued From page 44 smoking. Writer talked with patient to educate on smoking policy. Patient verbalized understanding stating "It was my last one anyway's." R3's Safe Smoking Evaluation form dated 2/4/24, was completed by the DON, identified the date recorded was 2/4/24 at 10:49 p.m. and the evaluation was completed at 10:50 p.m. The form had the same questions as the eval dated 1/4/24. The form identified the reason for assessment was "Re-Education" but did not specify the reason and/or what education was provided. All of the responses to the questions were marked "Yes" except for Resident uses or verbalizes a willingness to use flame retardant apron; "No" was selected. In response to IDT recommended resident receive the following smoking status. "Other - patient agrees not to smoke while at facility" was again selected. The evaluation did not clearly identify if R3 was safe to smoke independently. R3's care plan was revised on 2/4/24, added the interventions that notified staff R4 denied the use of smoking apron, but was aware one was available. R3's Non-Smoking Campus education document that was signed and dated by R3 and the DON on 2/4/24, included St. Gertrude's and the Garden's is a smoke free facility and campus. Resident verbalizes understanding standards and facility policy. Resident has been given education and information about smoking cessation. Resident verbalizes and consents with understanding about not sharing smoking materials with other residents. During an observation and interview on 2/7/24 at	F 689		

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	245610	A. BUILDING _____ B. WING _____	C 02/12/2024

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F 689	Continued From page 45 11:26 a.m., R3 was seated in a recliner and wore a blue short sleeved scrub top and bottom with a black long-sleeved shirt under it. R3 indicated cigarette usage was 1-2 cigarettes/day. R3 stated smoking supplies were kept in a knapsack on the floor of her room. R3 stated staff have never gone outside and observed a smoking session. R3 was unaware that smoking was only allowed off-campus. R3 indicated they were smoking outside the entrance to the TCU prior to receiving education that the facility was a smoke free campus. R3 indicated having a nicotine patch and pointed to right arm. During an interview on 2/7/24 at 3:23 p.m., NA-A stated R3 would tell staff she did not smoke, however she would see R3 going outside to smoke. During an observation on 2/8/24 at 7:35 a.m., DON gave R3 a piece paper that R3 signed after direction from DON that indicated that R3 had signed out of the building to smoke. R3 walked through the entrance of the TCU and attempted to light a cigarette while still on facility property. DON directed R3 twice that smoking was not allowed on facility campus. R3 walked to where smoking was permitted "off campus" and lit a cigarette while DON continued to observe smoking until R3's cigarette was extinguished. (No issues identified other than the reminders to not smoke on facility property and reminders to sign back in afterwards for the facility prevention interventions) During the walk back to R3's room, the DON reminded R3 to sign back in. R3 walked into her room and put her cigarettes in her knapsack on the floor.. DON reminded R3 that the smoking assessment was not complete because R3 had not signed back into the	F 689		

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F 689	Continued From page 46 building. R3 went to the nurse station and DON went behind the desk and gave R3 the paper to sign in. During a return phone call interview on 2/13/24 at 12:43 p.m., medical director (MD)-A indicated a safe comprehensive smoking assessment would need to determine the cognition of the resident along with the physical capabilities to safely handle smoking materials, the timeliness of these assessments would be to follow the facility policy. MD-A stated, "If a resident was prescribed nicotine replacement and was going to smoke any way, I would discontinue the nicotine replacement medication because the increase of nicotine can lead to harmful effects." MD-A further indicated the expectation to have a prescribed medication available to the resident from the time it was ordered would be no later than twenty-four hours. Manufacturer's package insert for CHANTIX included: is a nicotinic receptor partial agonist indicated for use as an aid to smoking cessation treatment. Directions for medication included: Begin CHANTIX dosing one week before the date set by the patient to stop smoking. Take CHANTIX exactly as prescribed by your doctor. 1. Choose a quit date when you will stop smoking. 2. Start taking CHANTIX 1 week (7 days) before your quit date. This lets CHANTIX build up in your body. You can keep smoking during this time. Make sure that you try and stop smoking on your quit date. If you slip-up and smoke, try again. Some people need to take CHANTIX for a few weeks for CHANTIX to work best. 5.4 Accidental injury: There have been postmarketing reports of traffic accidents, near-miss incidents in traffic, or other accidental	F 689		

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F 689	Continued From page 47 injuries in patients taking CHANTIX. In some cases, the patients reported somnolence, dizziness, loss of consciousness or difficulty concentrating that resulted in impairment, or concern about potential impairment, in driving or operating machinery. Facility policy, Non-Smoking-Tobacco Free Campus, dated 2017 did not address procedure/protocol for safe smoking assessments, supervision, monitoring and interventions for safety with smoking, further did not address procedures when a resident was deemed unsafe to smoke but continued to smoke on a non-smoking campus. The policy in it's entirety included; a purpose to provide safe living and working environment free of second-hand smoke and tobacco products. Policy identified no smoking, no use of tobacco products, and no use of electronic cigarettes are allowed in the building or on the grounds of the community. Procedure identified 1. residents and their responsible parties are notified of the smoke free campus prior to admission. 2. Residents admitted, who have been previous smokers/tobacco users, are supported with smoking cessation including orders from the attending physician. Undated Fire Policy and Procedure directed staff to R-Rescue anyone in immediate danger. A-alert other staff members of the fire and location over the intercom system. Pull the nearest fire alarm. The Person in Charge shall contact the fire department by calling 911. C-contain the fire. E-extinguish if the fire is small. The extinguisher should be aimed low at the base of the fire and move slowly upward with a sweeping motion.	F 689		

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F 689	Continued From page 48 The IJ which began on 2/8/24 was removed on 2/9/24 when the facility successfully implemented a removal plan which included: -comprehensively assessing all residents who smoke to include an observation -updating resident care plans with safety interventions. Care plans were individualized for each resident to safely smoke to include: smoking habits, availability of smoking aprons, monitoring for unsafe smoking practices such as burns on body and in clothing... -revised facility smoking policy to include: signing out when going outside to smoke, smoking cessation tools, safe smoking assessments, smoking apron availability, will consult with resident representative RR) or family member (FM) for supervision), attempt to work with resident RR, FM to encourage safe smoking while off campus, and residents who do not follow the safe smoking rules may have smoking materials removed up to a discharge. Educating all residents that the facility is a non-smoking campus, educated resident representative for residents who are not cognitive and if a resident was deemed not safe to smoke interventions may include providing additional supervision. Educated staff before the next shift on a non-smoking facility, reporting any signs of a resident smoking, immediately notify a supervisor of smoking, how to extinguish fires and educating residents and representatives about not sharing smoking materials. These interventions were verified as having been implemented on 2/9/24 evidenced by a review of observations, documentation and resident and staff interviews who verified education had been completed as outlined.	F 689		

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F 755	Continued From page 49	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 2 of 3	F 755	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan	3/12/24

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F 755	Continued From page 50 residents (R2 and R8) reviewed for resident safety. Findings include: R2's admission Minimum Data Set (MDS) dated 1/24/24 identified R2 to have intact cognition and and did not identify if tobacco was used. R2's provider note dated 1/19/24, identified R2 was a pack a day current smoker, will add Nicotrol inhaler for tobacco abuse. R2's provider note dated 1/23/24, identified R2 was a pack a day current smoker, Nicotrol inhaler for tobacco abuse was ordered supply has not arrived from the pharmacy. R2's January 2024 medication administration record (MAR), identified Nicotrol (nicotine) cartridge; 10 milligrams (mg) give every two hours as needed; puff for 20 minutes per cartridge. The MAR identified Nicotrol inhaler was not administered between 1/19/23 to 1/23/24. Corresponding nursing notes identified the medication was not given because the medication was not available. On 1/24/24 and 1/25/24 Nicotrol nasal spray non-aerosol; 10 mg/milliliter (ml) give a spray to nostril every hour as needed may repeat one spray if not effective. The MAR identified Nicotrol spray was not administered between 1/24/23 to 1/25/24. Corresponding nursing notes identified the medication was not given because the medication was not available. During an interview on 2/7/24 at 4:07 p.m. director of nursing (DON) reviewed R2's record and confirmed R2's Nicotrol inhaler or spray was not made available while at the facility due to	F 755	does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F755: Pharmacy Srvcs/Procedures/Pharmacist/Records CITED RESIDENT(S): R8 is no longer residing at facility and discharged on 2/6/2024. R2 is no longer residing at facility and discharged on 2/4/2024. Medical Record will be reviewed for Quality Assurance purposes. LIKE RESIDENT(S): All residents in house have been reviewed to have current medications available. EDUCATION: All licensed nurses and trained medication aides will be educated on procedure of missing/item not available related to medications and process of updating provider and pharmacy for alternative and/or direction. AUDIT: Director of Nursing or designee will audit the medication administration compliance report weekly for 4 weeks, then monthly for 2 months to verify the necessary follow up has been completed if medications were charted unavailable. Audit results will be reviewed by Quality Council monthly for further actions if needed.	

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F 755	Continued From page 51 problems with getting the medication from the pharmacy. R8's significant change (MDS) dated 1/31/24 identified R8 to have intact cognition and diagnoses of prostate cancer and a urinary tract infection (UTI) in the last 30 days, had an indwelling catheter and was currently receiving antibiotics. R8's December 2023 MAR, identified Bactrim (antibiotic medication) with a start date of 12/15/23 to 1/10/24. The MAR further identified Bactrim was not administered on 12/30/23 due to medication not available. R8's provider note dated 1/9/24 identified R8 was having hematuria (blood in urine), generalized weakness and positive urine culture to treat UTI with Cipro (antibiotic medication) 250 mg twice a day for seven days. R8's provider note dated 1/15/24 identified R8's Cipro course for UTI will be completed tomorrow on 1/16/24 and to resume Bactrim per urology orders after Cipro was completed. R8's physician orders included give Bactrim 400-80 milligrams (mg) every day for UTI prophylaxis per urologist (start date 1/22/24 with no stop date). R8's January 2024 MAR, identified the aforementioned physician orders with a start date of 1/22/24 to 2/8/24. The MAR further identified Bactrim was not administered on 1/23/23 due to medication not available, unable to find. R8 missed seven doses of Bactrim between 1/17/24 to 1/23/24 there was an 'X' (indicating not given)	F 755		

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F 755	Continued From page 52 placed in dates from 1/17/24 to 1/22/24. Cipro was not documented as given from 1/9/24 to 1/16/24 with 14 missed doses. During an interview on 2/12/24 at 2:04 p.m. director of nursing (DON) indicated doses of R8 antibiotics were not documented as given as ordered. DON's stated medications should be available to be given as ordered by the prescriber. During a phone interview on 2/13/24 at 12:43 p.m. medical director (MD)-A stated any prescribed medication to a resident should be available to the resident within 24 hours, if it's an antibiotic we would want it sooner than that. Facility policy Pharmacy Services dated 12/17, identified ... 7) Providing routine and timely pharmacy service as contracted and emergency pharmacy service 24 hours per day, seven days per week. b. All other new medication orders are received and available for administration on the next routine delivery, unless indicated otherwise by facility staff. Medications will be delivered by the primary pharmacy or back-up pharmacy or are available from the electronic medication cabinet (EMC) or emergency medication kit ... 13) Implementing procedures when medication delivery was delayed, or medications are not available. Facility policy unavailable medications dated 12/17, policy identified medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's	F 755		

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F 755	Continued From page 53 shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. Procedures: A. The pharmacy staff shall: 1) Call or notify nursing staff that the ordered product(s) is/are unavailable. 2) Notify nursing when it is anticipated that the drug(s) will become available. 3) Suggest alternative, comparable drug(s) and dosage of drug(s) that is/are available, which is covered by the resident's insurance. B. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medication. 3) Notify the pharmacy of the replacement order.	F 755		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/6/24, 2/7/24, 2/8/24 and 2/12/24, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when	2 000		

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2 000	Continued From page 1 they will be completed. The following complaints were reviewed: H56109564C (MN100557 and MN100704), H56109563 (MN100455), and H56109667C (MN100627) with a licensing order issued at 0830, 0900, and 1550 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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, develop and implement safe smoking interventions to reduce the risk of avoidable injuries with tobacco products for 4 of 4 residents (R2, R4, R7 and R3), who smoked. These failures resulted in an immediate jeopardy (IJ) for R2 who was smoking unsupervised outside the doors of facility's attached assisted living (AL), caught fire, sustained burns to 90% of her body, and died as a result of her injuries.	2 830	"Corrected"	3/12/24

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2 830	Continued From page 3 The IJ began on 2/1/24, when a recommendation from physical therapy identified R2 was not safe smoking independently unsupervised. The facility had not developed and implemented safe smoking interventions for R2 including but not limited to supervision. The administrator, director of nursing (DON), regional director of clinical services (RDCS)-A, Vice President of Clinical Services (VPCS)-A, Chief Operating Officer (COO)-A, and Vice President of Operations (VPO)-A were notified of the IJ for R2 on 2/8/24 at 12:41 p.m. The IJ was removed on 2/9/24 at 4:31 p.m. when an accepted removal plan was successfully implemented; however, non-compliance remained at an patterned scope with potential for more than minimal harm that is not immediate jeopardy (Level E). Findings include: Third degree burns penetrate the entire thickness of the skin and permanently destroy the tissue. These present a loss of layers, often painless (pain may be caused by patches of first- and second-degree burns surrounding the third-degree burns), and dry, leathery skin. Skin may appear charred or have patches that appear, white, brown, or black. The Saint Louis University Mental Status Exam (SLUMS)-a brief screening assessment used to detect cognitive impairment in adults over age 60. The SLUMS identified that a score of 27 to 30 means, normal in a person with a high school education; 21 to 26 mild neurocognitive disorder and 0 to 20 indicates dementia. Nursing Home Incident Report (NHIR) dated 2/4/24, identified an incident that the charge	2 830		

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2 830	Continued From page 4 nurse was notified R2 had caught on fire while smoking. EMS notified. Facility staff and passerby had extinguished the fire. R2 was transferred to the hospital for treatment. According to the facility census line (undated) R2 had been in room 400 on 2/4/24. During a facility walk through observation on 2/7/24, at 10:52 a.m. a path was walked from the nursing home room 400 where R2 resided to the AL entrance (location of where R2 smoked and caught on fire). The total distance from R2's 400 room to the AL outside exit/entrance was approximately 155 steps. There was a AL receptionist desk located at the main entrance/exit of the AL. At 11:03 a.m. outside directly in front of the AL sliding glass double doors entrance/exit, approximately three feet from the door there was a scattered amount of black substance identified by the video footage viewed on 2/7/24 as the location of the fire for R2. There was not a cigarette receptacle in this area nor was one visible in the video footage on 2/4/24, the day of the fire. R2's Slums assessment dated 11/8/23, identified a score of 22 of 30 which indicated mild cognitive impairment. R2's admission Minimum Data Set (MDS) dated 1/24/24, identified R2 had intact cognition and diagnoses of left scapula fracture and essential tremor. R2 used a wheelchair for mobility; walking 10 feet from an uneven turf was not attempted due to medical condition or safety concern and did not identify if tobacco was used. R2's progress note dated 1/18/24 at 10:22 p.m., identified R2 as a current everyday cigarette	2 830		

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2 830	Continued From page 5 smoker. R2's nurse practioner (NP) note dated 1/19/24 at 3:00 p.m., included a diagnosis of Tobacco abuse identifying R2 was a current one pack a day smoker and in the past had not been interested in quitting. Plan to add Nicotrol inhaler, counseled regarding smoking cessation. R2's progress note dated 1/21/24 at 1:48 p.m., identified R2 had tremors and to monitor when R2 was outside/ensure return due to cold weather. R2's Safe Smoking Evaluation dated 1/21/24, completed by RN-C identified the date recorded was 1/21/24 at 9:11 p.m. and the evaluation was completed at 9:12 p.m. (1 minute) The form was an electronic document that prompted staff to evaluate and click on the appropriate predefined response; most response options to choose were 'Yes' or 'No'. The reason for assessment was marked as "Admission" The form identified the following. -Resident has been given education and information about smoking cessation; "Yes" was selected -Resident demonstrates an understanding of the smoking standards and policy; "Yes" was selected -Resident demonstrates ability to make own decisions; "Yes" was selected. -Resident demonstrates ability to hold cigarette/cigar/pipe safely; "No" was selected -Resident demonstrates ability to light the smoking material safely with lighter/match; "No" was selected. -Resident uses or verbalizes a willingness to use a flame-retardant smoking apron; "No" was selected -Resident appropriately uses an ash receptacle	2 830		

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2 830	Continued From page 6 and does not drop ashes on self; "No" was selected -Resident demonstrates the ability to control holding the smoking material if bumped or distracted; "No" was selected. -Resident can safely extinguish the smoking material: "No" was selected -Resident complies with storage requirements for smoking material; "Yes" was selected. -Resident verbalizes and consents with understanding about not sharing smoking privileges with other residents "Yes" was selected. -Interdisciplinary Team (IDT) recommended resident to receive the following smoking status; (choices of selection included: Independent, Must be supervised, Smoking material must be secured, and Other) The only response selected was "Other-Resident is aware smoking is not prohibited on facility grounds. Resident chooses to decline nicotine patch and smoke in designated areas." The evaluation did not identify the reasons for the "No" selections, did not clearly identify if R2 was safe to smoke independently, and did not identify any education nor interventions provided for the boxes marked "No". R2's care plan dated 1/21/24, did not identify if R2 was safe to smoke independently nor safe smoking interventions if R2 chose to smoke. R2's care plan identified R2 had the potential for injury related by R2's choice to smoke. Interventions included: Ascertain resident wishes about smoking and respect residents decision, Evaluate for safety prior to smoking and screen per facility protocol, Instruct resident about smoking health effects on themselves and others, educate on risks and hazards, and provide resources for smoking cessation aides that are available. R2's	2 830		

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2 830	Continued From page 7 vulnerable adult care plan dated 1/22/24, included "I am a vulnerable adult and need assistance to remain safe within the community. My admitting diagnosis is Laceration without foreign body of scalp, subsequent encounter." In review of R2's record it was not evident R2 was provided/educated on the risk and benefits of smoking off campus independently, and instructions/interventions on what to do in the event of an emergent situation that required assistance even though R2's care plan informed staff R2 was at risk for injury and was vulnerable because she required assistance. During an interview on 2/7/24 at 9:37 a.m., registered nurse (RN)-C stated residents have the right to smoke at the facility but there was not a designated area for residents to smoke because the facility was non-smoking. The residents must go off campus to smoke (outside the AL) and needed to be able to smoke independently; the facility did not provide supervision. When a resident who smoked was admitted to the facility nursing would complete a smoking evaluation to determine if the resident was safe to smoke independently. The evaluation questions were reviewed with the smoking resident. RN-C would then watch the resident smoke to determine if they were safe. If the resident was determined to be an unsafe smoker RN-C would notify the administrator and the DON of the issue. Smoking supplies would be removed from the resident's possession with discussion and removal of supplies would be documented in the progress notes. A resident that would continue to smoke would be educated on a cessation program and the social worker and family would be included in those conversations. The clinical nurse manager would provide	2 830		

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2 830	Continued From page 8 education to residents upon admission and when staff reported concerns of smokers who were not smoking in the right area. R2's smoking evaluation was done in January and the evaluation demonstrated that R2 was not safe to smoke. RN-C stated that R2 was not visualized smoking for the smoking assessment. RN-C had previously visualized R2 smoking prior to nursing home admission when R2 resided at the attached AL. RN-C stated R2's family was aware R2 smoked however, was not sure if the family was made aware R2 was deemed unsafe to smoke after the assessment was completed. Further not aware if it was communicated to family member (FM)-A that R2 would not be supervised while smoking because the facility was non-smoking. R2's progress note dated 1/22/24 at 11:20 a.m., identified R2 telling unknown nursing assistant "I am going outside to smoke." At 11:25 a.m., identified R2 stating "I was disoriented. Didn't know where I was or what I was doing.", regarding a fall that occurred on 1/22/24. At 12:55 p.m., R2 had tremors, and safety precautions to monitor when patient outside/ensure return due to cold weather. Subsequent notes on 1/22/24 between 3:07 p.m. and 3:14 p.m. indicated Nicotrol (a nicotine replacement medication used to stop smoking) was not available, and the NP was notified. R2's Occupational Therapy (OT) treatment encounter note dated 1/23/24, identified R2 was 15 minutes late to treatment due to being outside smoking. SLUMS score was a 21/30 indicating mild cognitive impairment. R2's NP note dated 1/23/24, identified R2 continued to smoke outside and was counseled regarding smoking cessation. Nicotrol inhaler	2 830		

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2 830	Continued From page 9 ordered, supply has not arrived from pharmacy. R2 had used Chantix (medication used to stop smoking that does not contain nicotine) in the past was ineffective and caused nausea. Plan for Nicotrol inhaler (small hand-held inhalation device that contains nicotine cartridges) and R2 was counseled regarding smoking cessation, if Nicotrol inhaler ineffective would start Chantix along with Zofran for nausea. R2's progress note dated 1/24/24 at 3:54 p.m., identified R2 still smoked and would leave the unit without telling staff. R2's progress note dated 1/26/24 at 12:46 p.m., identified based on balance testing R2 was a high risk for falls and SLUMS 21/30. R2's OT treatment encounter note dated 1/26/24 at 3:25 p.m., identified care conference were held with R2, R2's family members, facility director and assisted living manager. Discussed safety with activities of daily living (ADL's) and falls. Notes had no mention of smoking status addressed or concerns with R1 smoking. R2's Associated Clinic of Psychology (ACP) note with a service date of 1/26/24, identified R2 with adjustment disorders and mixed disturbance of emotions and conduct. Within the mental status exam identified that R2 presented with probable reduced insight and judgement along with SLUMS subtest which indicated moderate cognitive impairment. R2 presented with deficits in calculation, executive functioning, and short-term memory. R2 stated to be a current every day smoker and had been counseled to quit. R2's progress note dated 1/28/24 at 11:03 a.m.,	2 830		

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2 830	Continued From page 10 identified R2 was still smoking and started on Chantix. Does leave unit to go smoking and to AL apartment-during the daytime. R2's physical therapy (PT) treatment encounter note dated 1/29/24 at 1:15 p.m., identified R2 not in room at scheduled therapy time due to being outside smoking. R2's progress notes dated 1/29/24, identified R2 as a current smoker, was on Chantix medication-day three and R2 was planning to go outside to smoke after moving to new room (in the nursing home). Review of R2's January and February 2024 medication administration (MAR) identified the prescribed medications that had the potential to help R2 quit smoking were not administered as prescribed: - Chantix: According January/February MAR identified Chantix start date of 1/27/23. R2 was administered Chantix 0.5 mg per physician order on 1/27/24, 1/28/24, and 1/29/24. Starting on 1/30/24, R2 was supposed receive 0.5 mg twice a day. The MAR identified R2 did not receive evening doses on 1/31/24, 2/1/24, 2/3/24, and neither doses were administered on 2/4/24. The dose on 2/3/24, note identified R2 "did not want to take." -Nicotrol inhaler: January/February 2024 MAR identified Nicotrol (nicotine) cartridge; 10 milligrams (mg) give every two hours as needed; puff for 20 minutes per cartridge. Nicotrol inhaler was not administered between 1/19/23 to 1/23/24. Corresponding nursing notes from 1/19/24 to 1/22/24 identified the medication was not given because the medication was not available. -Nicotrol nasal spray: January/February MAR	2 830		

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2 830	Continued From page 11 identified Nicotrol nasal spray non-aerosol; 10 mg/milliliter (ml) give a spray to nostril every hour as needed may repeat one spray if not effective. The MAR identified Nicotrol spray was never administered. R2's OT treatment encounter note dated 1/31/24, identified OT attempted therapy three times that afternoon and each time R2 was out of the building smoking. Undated Facility eSource document indicated the administrator identified a concern on 1/31/24 at 4:20 p.m., R2 was smoking on facility grounds. Expectations/desired outcome as R2 was to not smoke on a non-smoking campus. R2's progress note dated 1/31/24 at 9:21 p.m., identified staff stated R2 was not safe to smoke outside by self. R2 replied that her mind was intact, and she can go outside and smoke on her own. R2's progress note dated 2/1/24 at 1:04 p.m., authored by the DON included "Resident was outside smoking and self-propelling backwards in wheelchair into building." Resident indicated she has been smoking and not cutting back. "Educated resident on smoking with Chantix and safe smoking practices/non-smoking campus." Resident verbalized understanding at the time of the conversation. (staff name) updated and indicated that family was bringing in cigarettes and was going to stop moving forward to assist in supporting resident with cessation. R2's record does not define/specify which "safe smoking practices" were provided. R2's PT discharge summary note dated 2/1/24, identified R2 as a smoker and would go outside in	2 830		

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2 830	Continued From page 12 wheelchair very often to smoke. A recommendation for R2 to a LTC (long term care) placement that allows smoking somewhere right outside the door so R2 can be supervised and in a safe location. R2's OT discharge summary note dated 2/1/24 identified R2 has limitations due to safety and recommendation for higher level of care and monitoring, recommend assist with all ADLs. During an interview on 2/8/24 at 7:36 a.m., physical therapist (PT)-A indicated R2 had been on their patient load several times. PT-A identified R2 was an avid smoker, did not want to quit smoking, and continued to smoke throughout R2's stay. PT-A stated R2 was not safe to be in the community independently, this was why R2 was moved from her assisted living to long term care. R2 kept falling and hurting herself, this last time R2 had a huge laceration to the side of the head requiring several stitches. PT-A stated, "[R2] was not necessarily demented, but made terrible choices, did not care about safety and was very impulsive." R2 was a danger to herself and needed more supervision, we tried to provide that. When R2's cigarette supplies were taken away, she somehow kept getting more. "We have been trying to prevent [R2] from smoking because it was absolutely not safe for her to be doing it on her own." Physical therapy assistant (PTA)-A stated "[R2] was at least a pack a day smoker." PTA-A further indicated R2 missed a few days of therapy due to smoking. PTA-A indicated visualizing cigarette burns on R2's clothing on several different occasions. Undated Facility eSource document indicated the administrator identified a concern on 2/2/24 at 1:00 p.m., R2 was smoking on a non-smoking	2 830		

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2 830	Continued From page 13 campus. Assisted living clinical manager noted R2 to be smoking on facility grounds, was re-educated, and told R2 to not smoke. DON confiscated R2's smoking materials. During an interview on 2/7/24 at 2:06 p.m., trained medication aide (TMA)-A indicated if a resident smoked it would be on the care plan. Residents kept smoking materials on them and should "sign out" at the front desk by the AL entrance when they go out to smoke. Staff did not supervise residents who smoked nor check for burns on their body or clothing after the resident got done smoking. TMA-A was not able to articulate how residents would communicate or notify staff if they needed help outside without staff. During an interview on 2/7/24 at 2:12 p.m., nursing assistant (NA)-B stated staff did not check residents that smoked for holes burned into clothing or body parts after they were done smoking. Residents that smoke without supervision had no way to alert staff if they needed help. During an interview on 2/7/24 at 3:23 p.m., NA-A identified R2 was known to go out and smoke. NA-A would see R2 outside smoking, but staff did not have to go outside with her. During an observation on 2/7/24 at 3:25 p.m., R2 had two clear plastic bags labeled with name in a closet in the room where R2 resided. A size large blue Columbia half zip fleece pullover with no hood was in the bag. The pullover contained a burn mark located by the left breast area zipper, two burn holes on the left sleeve and a burn hole on the cuff of the sleeve.	2 830		

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2 830	Continued From page 14 During an interview on 2/7/24 at 3:33 p.m., licensed practical nurse (LPN)-B stated R2 was a smoker and used to see R2 outside smoking but never with any staff. LPN-B was unable to articulate safety interventions or protocols for residents who were determined unsafe to smoke but smoked without supervision. During an interview on 2/8/24 at 8:17 a.m., receptionist (R)-A stated "[R2] smoked a lot" since admission and would smoke at the front entrance without any staff supervision. R2 always wore a long dark jacket and had noticed burn holes in the fur hood of R2's jacket. During an interview on 2/8/24 at 8:23 a.m., RN-A indicated working the day shift on 2/4/24, R2 would usually smoke out of the transitional care unit (TCU) entrance and was not aware if R2 needed supervision to smoke. RN-A had never checked R2 for burns on her clothing or body after she came in from outside. Even though R2's record identified R2 was not safe to smoke, the record had multiple documented occurrences on 1/22/24, 1/23/24, 1/24/24, 1/28/24, 1/29/24, 1/31/24, and 2/1/24 of staff's awareness of R2's plan to go outside to smoke and/or was witnessed by staff outside smoking. There was not indication the facility identified any immediate safety interventions implemented for R2. Nor does the record identify documentation of assessments completed after smoking for burn holes on clothing. . During an interview on 2/7/24 at 3:25 p.m., NA-C stated on 2/4/23, at approximately 5:30 p.m. R2 was in her room standing near the bed putting her jacket on. NA-C reported no direction had ever been given to supervise R2 when smoking. NA-C	2 830		

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2 830	Continued From page 15 stated unawareness of monitoring skin or clothing after smoking. R2's progress note dated 2/4/24 at 6:30 p.m., identified "was updated that R2 noted to have an incident related to smoking causing burns. Nursing staff immediately responded, 911 was called by nursing staff. R2 was transferred to hospital emergency room (ER) via ambulance. NP and family updated." During a return phone interview on 2/15/24 at 1:50 p.m., NA-D who was working at the time of the incident stated that on 2/4/24, he was working on the 200 hallway and had been near the dining room when he saw and heard an unidentified visitor come around the corner yelling "come, come, fire, fire!". The unidentified visitor told him the fire was outside. NA-D then went outside the AL door to find R2 on fire, "the fire was huge." NA-D ran back inside passing two nurses who went outside. NA-D stated he then grabbed the fire extinguisher and handed it to someone else and let them put the fire out. During an interview on 2/8/24 at 3:40 p.m., LPN-A identified she worked the evening of 2/4/24 as the charge nurse of the building. LPN-A stated around 5:30 p.m. R2 had finished eating and was noted to be having urinary tract infection symptoms. R2 always wore a jacket with the furry hood that had a quarter sized burn hole on the lower part of her jacket and a dime sized burn whole near the front chest of the jacket. R2 was a known frequent smoker; she would go out and smoke at least twice a shift. LPN-A's recollection of events were, "I heard a male voice yelling Fire, Fire, Fire! so I was walking near the fire doors, he said help help help she is on fire. I followed the sound of the man's voice and it was out the AL	2 830		

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2 830	Continued From page 16 doors." LPN-A stated she saw R2 outside the doors about three feet from the building seated in the wheelchair and R2 was completely engulfed in flames." LPN-A looked for the fire extinguisher but could not see through all the smoke. LPN-A grabbed a half pitcher of water located on the medication cart, grabbed a blanket, and ran back outside. RN-B dumped the water on R2 and someone "started hitting [R2] with the blanket" and "That's when the flames went way above R2's head." LPN-A stated she "told an aide to call 911" and RN-B used the fire extinguisher to put the fire out. The paramedic asked R2 to state their name and R2 responded in a very soft voice, her name and answered yes to having pain. Review of the facility video footage of 2/4/24, identified at 6:00 p.m. R2 had wheeled self out of the automatic double doors of the AL entrance and stopped approximately three feet from the building and lit a cigarette, no cigarette receptacle was observed. R2 was not wearing oxygen nor was there an oxygen tank on or around her wheelchair. R2 wore a dark long jacket that was unzipped with a hood brimmed with long fur. Between 6:00 p.m and 6:07 p.m. R2 can be seen intermittently leaning forward in her wheelchair so that her head was half way to her knees while she continued to smoke. At 6:07 p.m. R2's jacket on the left side was visualized to be on fire (either the bottom of her coat or the cuff of her coat), R2 stood up, and attempted to remove jacket, R2 removed right jacket sleeve at 6:08 p.m. 15 seconds later R2's shirt caught on fire, about 20 seconds later R2 threw the jacket on the ground and R2's legs caught on fire, R2 fell back into the wheelchair. At 6:09 p.m. R2's left arm was also on fire, R2's head/shoulders were engulfed in flames by 6:10 p.m. An elderly unknown male came out of the facility at 6:10 p.m. and	2 830		

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2 830	Continued From page 17 attempted to move R2's wheelchair without success and then went back into the facility. R2 stood up again, her feet were engulfed in flames. At 6:10 p.m. and 54 seconds an unknown facility male staff came out of the facility looked at R2 and went back in the facility. Then another unknown facility male staff came out of the door and tried to remove clothing off of R2, staff came out with a blanket and put the blanket around R2's left side without smothering the flames while the other male staff member vigorously and rapidly moved blanket up and down over in a fanning motion which seemed to increase the flames. Shortly after a pitcher of water was thrown on R2. At 6:12 p.m. a fire extinguisher was activated within two feet and sprayed directly at R2 (ABC fire extinguisher-an extinguisher that uses a powder chemical to extinguish a fire). The fire was extinguished at 6:12 p.m. and 27 seconds. Emergency medical services (EMS) attended to R2 at 6:15 p.m. R2 was engulfed in flames from 6:07 p.m. to 6:12 p.m. for almost a full 5 minutes. During a phone interview on 2/14/24 at 1:39 p.m., investigations sergeant (IS)-A indicated they reviewed the facility video from 2/4/24. IS-A stated R2 was unsupervised had wheeled self out the doors and was smoking a cigarette when R2's clothing caught on fire. "R2 was on fire for almost a full five minutes and was completely engulfed in flames, the whole facility could have gone up in flames." IS-A stated this was completely preventable, it would have been so easy to help R2, all the facility had to do was provide adequate supervision. The Shakopee Police Department Incident Report dated 2/4/24, identified officers arrived on the scene at 6:13 p.m., identified and recorded	2 830		

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2 830	Continued From page 18 statements from six members of the police department that were on scene. Statements indicated that R2 was no longer on fire but appeared that R2 had been fully engulfed in flames at one point, a nurse was holding R2 in what remained of the frame of the wheelchair that the fire had disintegrated the padding. R2's legs were caught inside the chair. R2's clothing was all burnt off and personal items on the ground near R2 included shoes, glasses, keys, one blanket, one sheet, a cell phone, empty cigarette boxes and cigarettes. R2 was assisted out of the wheelchair and onto a blanket. Investigation showed that R2 was a smoker and often went outside in that area to smoke cigarettes. During a phone interview on 2/13/24 at 2:38 p.m., police officer (PO)-A indicated being called to the facility on 2/4/24 sometime after 6:00 p.m. R2 was naked, body covered in burns seated in a wheelchair, the seat had melted away. PO-A stated RN-B reported to her R2 had been smoking for quite some time, R2 had snuck out of the building to smoke, and staff did not provide supervision to the residents that smoked. PO-A stated, "R2 was helpless seated in the wheelchair and literally started on fire, someone should have noticed R2 went out, this would have been completely preventable." The hospital Health Emergency Medical Services (EMS) document dated 2/4/24, identified ambulance arrived on scene, 2/4/24 at 6:18 p.m., R2 had third degree burns over 70% of body, full thickness burns from mid thighs down to feet. R2 had soot and burns and the dry chemical from fire extinguisher in nares (nostrils) and mouth and arrived at the hospital at 6:43 p.m. R2's Healthcare Burn Unit Emergency	2 830		

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2 830	Continued From page 19 Department (ED) provider note dated 2/4/24, identified R2 had deep third degree burns to 90% of the body with the only area spared being the right upper back. Injuries reported were suspected from R2 smoking at the time. Proximate cause of death was full thickness burns and immediate cardiopulmonary arrest (sudden loss of all heart activity). During a phone interview on 2/12/24 at 3:42 p.m., family member (FM)-A explained R2 was living at the AL building but was not safe to be there unsupervised and needed a nursing home. R2 had a long history of hand tremors that would cause her to occasionally drop lit cigarettes that would cause burns on her hands and clothing. R2 also had a history of falling asleep while smoking cigarettes and has had several falls. FM-A thought R2 would be much safer at the nursing home because she would have increased supervision. FM-A explained R2 had historically successfully quit smoking using a Nicotrol inhaler. Upon admit to the LTC facility R2 had been offered Nicotrol inhaler, but it never showed up. FM-A stated R2 called her during the day of 2/4/24, her words were slurred. FM-A thought something was not right. During the call R2 asked FM-A "can I smoke if I get off the Chantix?" FM-A stated she told R2 "to not smoke because the facility did not want her smoking." FM-A was crying as she recalled the first call she received about the fire on 2/4/24. FM-A stated the hospital called her before the facility. The hospital told FM-A that R2 had sustained burns that covered 85%-90% of her body and it was not survivable. When FM-A arrived at the hospital to say good-bye to R2. She was in the hospital elevator when she received a call from the DON and administrator. They told her R2 had gotten a hold of cigarettes and "started a little fire," that was put	2 830		

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2 830	Continued From page 20 out within 60 seconds, and R2 was sent to the hospital. "They made it sound like no big deal! Had the hospital not called me I would have gone to bed and dealt with it in the morning." FM-A asked the facility for more details but no one would tell her. FM-A stated, "I just want to know that [R2] didn't suffer!" FM-A continued to cry as she identified what she saw when entering (R2's) hospital room. R2's hair was singed, her face was blackened. The doctor told her she did not want to see what was under the bandages, R2 died that night. FM-A stated R2's friend who smoked with (R2) over at the AL informed her that after R2's accident. R2 had been leaning to one side for a couple of days prior to the incident. FM-A thought in looking back, she questioned if R2 had a stroke. R2's friend also informed FM-A that she was offered a smoking apron. FM-A stated that was never offered to (R2), "why didn't the facility offer [R2] a smoking apron!?" FM-A stated the facility had never offered an apron to her and had never seen any residents with smoking aprons. "A smoking apron would have saved [R2's] life, [R2] never should have died like that." During an interview on 2/7/24 at 4:07 p.m., Administrator and director of nursing (DON) both identified the facility as a "non-smoking campus; residents who smoked, must smoke off-campus on the sidewalk in front of the building." DON further identified if a resident was deemed to be an unsafe smoker, then nicotine replacement was offered, resident's smoking material were removed, family would be involved to help the resident quit, and IDT involvement. DON indicated R2 was a smoker prior to admission and R2 continued to smoke during her stay, however R2 had never been observed smoking from start to finish as part of the smoking assessment to determine level of risk or	2 830		

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2 830	Continued From page 21 necessary safety interventions. DON expected observations and a smoking evaluation to be completed with an active smoker on admission, quarterly and with a significant change as part of the smoking assessment. DON and administrator stated the facility's strategies to keep R2 safe included: the physician ordered nicotine replacement on 1/19/24, but was never available due to a pharmacy issue. On 1/26/24, physician ordered Chantix to help stop smoking. On 1/29/24, R2 was deemed unsafe to smoke outside due to R2 not physically able to wheel herself back into the facility. Additionally on 1/31/24, R2's smoking materials were taken away. On 2/1/24, and 2/2/24, R2's smoking materials were again removed when R2 was found smoking on facility ground. R2 was also re-educated of the smoke free campus, the physician was notified, and a discussion with family who agreed not to provide R2 with smoking materials. DON indicated after the incident on 2/4/24, she came to the facility to reassess R3, R4, and R7. DON stated she completed the assessments by watching the residents smoke from the doorway of the gardens inside the facility. This was approximately 30-35 yards away from the designated smoking area. DON stated based on the assessments all three residents were deemed safe to smoke. The DON offered them smoking aprons and were re-educated on the need to sign out in the book to go out and smoke off campus. The administrator stated, we are a non-smoking facility, and residents need to be off campus to smoke. If residents were deemed unsafe to smoke, education is provided, smoking supplies are removed, and a discussion with family. When a resident signs out to go off campus the resident was assuming responsibility we are not here to	2 830		

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2 830	Continued From page 22 oversee and supervise them. Sign out sheets to go off campus for R2 were requested and never received. During an interview on 2/8/24 at 9:56 a.m., the administrator stated they had completed the investigation for R2. The administrator stated, "the root cause of R2's accident was noncompliance with R2 making a poor decision." R4's undated face sheet identified R4 had diagnoses of nicotine dependence, epilepsy with status epilepticus , diabetes, difficulty in walking, muscle weakness, and long term use of anticoagulants. R4's quarterly MDS assessment dated 11/22/23, identified R4 to have moderate cognitive impairment and used a walker independently with walking. R4's care plan dated 4/24/23, identified a behavior problem with the potential for injury related to R4's choice to smoke. Interventions were to notify the clinical manager immediately if it is suspected resident had violated smoking rules and support resident with smoking cessation in collaboration with the attending physician if the resident decides to stop smoking. R4's vulnerable adult care plan dated 12/6/23, included "I am a vulnerable adult and need assistance to remain safe within the community. My vulnerabilities include vulnerable to abuse from others." R4's Safe Smoking Evaluation Dated 1/14/24, completed by the DON identified the date recorded was 1/14/24 at 9:46 p.m. and the	2 830		

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2 830	Continued From page 23 evaluation was completed at 9:48 p.m. The form was an electronic document that prompted staff to evaluate and click on the appropriate predefined response; most response options to choose were 'Yes' or 'No'. The reason for assessment was marked as "Annual" The form identified the following. -Resident has been given education and information about smoking cessation; "Yes" was selected -Resident demonstrates an understanding of the smoking standards and policy; "Yes" was selected -Resident demonstrates ability to make own decisions; "Yes" was selected. -Resident demonstrates ability to hold cigarette/cigar/pipe safely; "No" was selected -Resident demonstrates ability to light the smoking material safely with lighter/match; "No" was selected. -Resident uses or verbalizes a willingness to use a flame retardant smoking apron; "No" was selected -Resident appropriately uses an ash receptacle and does not drop ashes on self; "No" was selected -Resident demonstrates the ability to control holding the smoking material if bumped or distracted; "No" was selected. -Resident can safely extinguish the smoking material: "No" was selected -Resident complies with storage requirements for smoking material; "No" was selected. -Resident verbalizes and consents with understanding about not sharing smoking privileges with other residents "No" was selected. -IDT recommends resident receive the following smoking status; (choices included: Independent, Must be supervised, Smoking material must be secured, and Other) The only response selected	2 830		

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2 830	Continued From page 24 was "Other-Resident is aware smoking is "not prohibited on facility grounds"" The evaluation did not identify the reasons for the "No" selections, did not clearly identify if R4 was safe to smoke independently, and did not identify any education nor interventions provided for the boxes marked "No". R4's Safe Smoking Evaluation form dated 2/4/24, was completed by the DON, identified the date recorded was 2/4/24 at 10:40 p.m. and the evaluation was completed at 10:43 p.m. The form had the same questions as the eval dated 1/14/24. The form identified the reason for assessment was "Re-Education" but did not specify the reason and/or what education was provided. All of the responses to the questions were marked "Yes" except for Resident uses or verbalizes a willingness to use flame retardant apron; "No" was selected. "Other-Resident is aware smoking is "not prohibited on facility grounds"" was again selected in response to IDT recommends resident receive the following smoking status. The evaluation did not clearly identify if R4 was safe to smoke independently, and did not identify any education nor interventions provided for the boxes marked "No". R4's Non-Smoking Campus education document that was signed and dated by R4 and the DON on 2/4/24, included St. Gertrude's and the Garden's is a smoke free facility and campus. Resident verbalizes understanding standards and facility policy. Resident has been given education and information about smoking cessation. Resident verbalizes and consents with understanding about not sharing smoking materials with other residents.	2 830		

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2 830	Continued From page 25 R4's progress note dated 2/4/24 at 10:43 p.m. authored by the DON included Resident was re-educated on the facility being a smoke free campus. Resident verbalized understanding of smoking standards and facility policy. Writer did offer a smoking apron in the event resident choose to go out and smoke and resident denied. Resident given re-education and information on smoking cessation. Resident verbalizes understanding and consents with understanding about not sharing smoking materials with other residents. R4's care plan was revised on 2/4/24, added the interventions that notified staff R4 denied the use of smoking apron, but was aware one was available. In review of R4's record it was not evident R4 was provided/educated on the risk and benefits of using a smoking apron, smoking off campus independently, and instructions/interventions on what to do in the event of an emergent situation that required assistance even though R4 was at risk for injury according to her care plan dated 4/24/23. During an observation and interview on 2/7/24 at 1:39 p.m., R4 was on the sidewalk by the AL with a lit Old Gold brand cigarette. R4 was standing and hanging on to the handles of a four wheeled seated walker. The brakes were not engaged on the walker. R4 wore a long, black winter jacket that went to the knees and was zipped, no glove use noted. R4 indicated cigarette usage was 4-5 cigarettes per day and the smoking supplies were kept in the purse. R4 stated that staff have never went outside and observed a smoking session. When the weather was bad, all of the smokers smoked under the AL canopy. R4 stated that	2 830		

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2 830	Continued From page 26 since R2 had a burn incident the staff make them sign out to smoke. R4 removed a plastic pop container filled with cigarette butts and a dark brown liquid from a purse. R4 sat without engaging the brakes on the walker, the cigarette hanging out of her mouth had a long chain of ash burning (approximately 2/3 of the cigarette) as R4 had not discarded any ashes from the lit cigarette and with the cigarette hanging out of her mouth she rotated 180 degrees to sit on the walker as the ashes fell to the ground. R4 proceeded to smoke the cigarette down to the filter, unscrewed the lid from the pop bottle, dropped the still burning cigarette filter into the pop bottle without extinguishing it and screwed the lid back on the pop bottle. R4 then placed the plastic bottle inside her purse. R4 indicated she always used the pop bottle for her cigarette butts. R4 stated there was no way to notify the staff for help while outside. R7's quarterly MDS assessment dated 11/7/23, R7 to have intact cognition and diagnoses of diabetes, anxiety, depression and tobacco abuse. R7 used a walker and wheelchair for mobility. Current tobacco use was not assessed. R7's care plan dated 5/18/23, identified a behavior problem with the potential for injury related to R7's choice to smoke and interventions were to notify the clinical manager immediately if it is suspected resident had violated smoking rules and support resident with smoking cessation in collaboration with the attending physician if the resident decides to stop smoking. R7's vulnerable adult care plan dated 11/20/23, included I am vulnerable adult and need assistance to remain safe within the community. My vulnerabilities include but not limited to: vulnerable to abuse from others, at risk for	2 830		

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2 830	Continued From page 27 abusing others, anxiety, opioid dependence and depression. R7's Safe Smoking Evaluation Dated 1/14/24, completed by the DON identified the date recorded was 1/14/24 at 9:52 p.m. and the evaluation was completed at 9:53 p.m. The form was an electronic document that prompted staff to evaluate and click on the appropriate predefined response; most response options to choose were 'Yes' or 'No'. The reason for assessment was marked as "Annual" The form identified the following. -Resident has been given education and information about smoking cessation; "Yes" was selected -Resident demonstrates an understanding of the smoking standards and policy; "Yes" was selected -Resident demonstrates ability to make own decisions; "Yes" was selected. -Resident demonstrates ability to hold cigarette/cigar/pipe safely; "No" was selected -Resident demonstrates ability to light the smoking material safely with lighter/match; "No" was selected. -Resident uses or verbalizes a willingness to use a flame retardant smoking apron; "No" was selected -Resident appropriately uses an ash receptacle and does not drop ashes on self; "No" was selected -Resident demonstrates the ability to control holding the smoking material if bumped or distracted; "No" was selected. -Resident can safely extinguish the smoking material: "No" was selected -Resident complies with storage requirements for smoking material; "No" was selected. -Resident verbalizes and consents with	2 830		

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2 830	Continued From page 28 understanding about not sharing smoking privileges with other residents "No" was selected. -IDT recommends resident receive the following smoking status; (choices included: Independent, Must be supervised, Smoking material must be secured, and Other) The only response selected was "Other-Resident is aware that facility policy is no smoking on facility grounds." The evaluation did not identify the reasons for the "No" selections, did not clearly identify if R7 was safe to smoke independently, and did not identify any education nor interventions provided for the boxes marked "No". R7's Safe Smoking Evaluation form dated 2/4/24, was completed by the DON, identified the date recorded was 2/4/24 at 10:33 p.m. and the evaluation was completed at 10:34 p.m., one minute later The form had the same questions as the eval dated 1/14/24. The form identified the reason for assessment was "Re-Education" but did not specify the reason and/or what education was provided. All of the responses to the questions were marked "Yes" except for Resident uses or verbalizes a willingness to use flame retardant apron; "No" was selected. "Other-Resident is aware facility policy is no smoking on facility grounds,"was again selected in response to IDT recommends resident receive the following smoking status. The evaluation did not clearly identify if R7 was safe to smoke independently, and did not identify any education nor for interventions provided for the boxes marked "No". During an interview on 2/7/24 at 2:48 p.m., R7 was noted to walk out of his room using a wheeled walker. R7 stated, "I am more of a night owl and like to smoke in the middle of the night, no nurse here has ever watched me smoke a	2 830		

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2 830	Continued From page 29 cigarette." During an interview on 2/7/24, at 2:19 p.m., interim Clinical Manager (CM)-A stated upon notification that a resident smoked, a comprehensive smoking assessment was completed. The assessment included an observation of the resident smoking including safe storage of smoking materials, lighting the cigarette, appropriate ashing, extinguishing the cigarette and ability to place the butt in an appropriate receptacle. In addition, the resident's cognition and dexterity were also considered to determine safety. CM-A identified two residents who smoked, R4 and R 7 were both safe to smoke unsupervised. Residents keep their own cigarettes and lighter on them. If a resident who was not safe to smoke went outside, then staff would have to provide supervision to keep them safe. CM-A was unable to articulate how a resident would alert staff if they needed help while outside smoking without supervision. R3's admission MDS dated 1/15/24, identified R3 to have intact cognition and diagnoses of cellulitis of left lower limb, dialysis dependent, difficulty walking, muscle weakness, and nicotine dependence. R3 used a walker and wheelchair for mobility. Walking 10 feet from uneven turf was not attempted due to medical condition or safety concern and currently used tobacco. R3's care plan dated 12/30/23, identified a safety problem with the potential for injury related to R3's choice to smoke. Interventions were to notify the clinical manager immediately if it is suspected resident had violated smoking rules and support resident with smoking cessation in collaboration with the attending physician if the resident	2 830		

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2 830	Continued From page 30 decides to stop smoking. R3's vulnerable adult care plan included "I am a vulnerable adult related to resident in a skilled nursing facility, stated medical diagnoses, and dependent on others for cares." R3's Safe Smoking Evaluation dated 1/4/24, completed by RN-C identified the date recorded was 1/4/24 at 6:44 a.m. and the evaluation was completed at 6:47 a.m., three minutes later. The form was an electronic document that prompted staff to evaluate and click on the appropriate predefined response; most response options to choose were 'Yes' or 'No'. The reason for assessment was marked as "Admission" The form identified the following. -Resident has been given education and information about smoking cessation; "Yes" was selected -Resident demonstrates an understanding of the smoking standards and policy; "Yes" was selected -Resident demonstrates ability to make own decisions; "Yes" was selected. -Resident demonstrates ability to hold cigarette/cigar/pipe safely; "No" was selected -Resident demonstrates ability to light the smoking material safely with lighter/match; "No" was selected. -Resident uses or verbalizes a willingness to use a flame-retardant smoking apron; "No" was selected -Resident appropriately uses an ash receptacle and does not drop ashes on self; "No" was selected -Resident demonstrates the ability to control holding the smoking material if bumped or distracted; "No" was selected. -Resident can safely extinguish the smoking material: "No" was selected	2 830		

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2 830	Continued From page 31 -Resident complies with storage requirements for smoking material; "No" was selected. -Resident verbalizes and consents with understanding about not sharing smoking privileges with other residents "No" was selected. -IDT recommended resident receive the following smoking status; (choices of selection included: Independent, Must be supervised, Smoking material must be secured, and Other) The only response selected was "Other- patient agrees not to smoke while at facility." The evaluation did not identify the reasons for the "No" selections, did not clearly identify if R3 was safe to smoke independently, and did not identify any education nor interventions provided for the boxes marked "No". R3's late entry progress note dated 1/26/24 for 1/25/24 at 3:36 p.m., indicated a nurse went to meet with R3 "but was not in her room. Found patient sitting by TCU door on bench outside smoking. Writer talked with patient to educate on smoking policy. Patient verbalized understanding stating "It was my last one anyway's." R3's Safe Smoking Evaluation form dated 2/4/24, was completed by the DON, identified the date recorded was 2/4/24 at 10:49 p.m. and the evaluation was completed at 10:50 p.m. The form had the same questions as the eval dated 1/4/24. The form identified the reason for assessment was "Re-Education" but did not specify the reason and/or what education was provided. All of the responses to the questions were marked "Yes" except for Resident uses or verbalizes a willingness to use flame retardant apron; "No" was selected. In response to IDT recommended resident receive the following smoking status. "Other - patient agrees not to smoke while at facility" was again selected.	2 830		

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2 830	Continued From page 32 The evaluation did not clearly identify if R3 was safe to smoke independently. R3's care plan was revised on 2/4/24, added the interventions that notified staff R4 denied the use of smoking apron, but was aware one was available. R3's Non-Smoking Campus education document that was signed and dated by R3 and the DON on 2/4/24, included St. Gertrude's and the Garden's is a smoke free facility and campus. Resident verbalizes understanding standards and facility policy. Resident has been given education and information about smoking cessation. Resident verbalizes and consents with understanding about not sharing smoking materials with other residents. During an observation and interview on 2/7/24 at 11:26 a.m., R3 was seated in a recliner and wore a blue short sleeved scrub top and bottom with a black long-sleeved shirt under it. R3 indicated cigarette usage was 1-2 cigarettes/day. R3 stated smoking supplies were kept in a knapsack on the floor of her room. R3 stated staff have never gone outside and observed a smoking session. R3 was unaware that smoking was only allowed off-campus. R3 indicated they were smoking outside the entrance to the TCU prior to receiving education that the facility was a smoke free campus. R3 indicated having a nicotine patch and pointed to right arm. During an interview on 2/7/24 at 3:23 p.m., NA-A stated R3 would tell staff she did not smoke, however she would see R3 going outside to smoke. During an observation on 2/8/24 at 7:35 a.m.,	2 830		

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2 830	Continued From page 33 DON gave R3 a piece paper that R3 signed after direction from DON that indicated that R3 had signed out of the building to smoke. R3 walked through the entrance of the TCU and attempted to light a cigarette while still on facility property. DON directed R3 twice that smoking was not allowed on facility campus. R3 walked to where smoking was permitted "off campus" and lit a cigarette while DON continued to observe smoking until R3's cigarette was extinguished. (No issues identified other than the reminders to not smoke on facility property and reminders to sign back in afterwards for the facility prevention interventions) During the walk back to R3's room, the DON reminded R3 to sign back in. R3 walked into her room and put her cigarettes in her knapsack on the floor.. DON reminded R3 that the smoking assessment was not complete because R3 had not signed back into the building. R3 went to the nurse station and DON went behind the desk and gave R3 the paper to sign in. During a return phone call interview on 2/13/24 at 12:43 p.m., medical director (MD)-A indicated a safe comprehensive smoking assessment would need to determine the cognition of the resident along with the physical capabilities to safely handle smoking materials, the timeliness of these assessments would be to follow the facility policy. MD-A stated, "If a resident was prescribed nicotine replacement and was going to smoke any way, I would discontinue the nicotine replacement medication because the increase of nicotine can lead to harmful effects." MD-A further indicated the expectation to have a prescribed medication available to the resident from the time it was ordered would be no later than twenty-four hours.	2 830		

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2 830	Continued From page 34 Manufacturer's package insert for CHANTIX included: is a nicotinic receptor partial agonist indicated for use as an aid to smoking cessation treatment. Directions for medication included: Begin CHANTIX dosing one week before the date set by the patient to stop smoking. Take CHANTIX exactly as prescribed by your doctor. 1. Choose a quit date when you will stop smoking. 2. Start taking CHANTIX 1 week (7 days) before your quit date. This lets CHANTIX build up in your body. You can keep smoking during this time. Make sure that you try and stop smoking on your quit date. If you slip-up and smoke, try again. Some people need to take CHANTIX for a few weeks for CHANTIX to work best. 5.4 Accidental injury: There have been postmarketing reports of traffic accidents, near-miss incidents in traffic, or other accidental injuries in patients taking CHANTIX. In some cases, the patients reported somnolence, dizziness, loss of consciousness or difficulty concentrating that resulted in impairment, or concern about potential impairment, in driving or operating machinery. Facility policy, Non-Smoking-Tobacco Free Campus, dated 2017 did not address procedure/protocol for safe smoking assessments, supervision, monitoring and interventions for safety with smoking, further did not address procedures when a resident was deemed unsafe to smoke but continued to smoke on a non-smoking campus. The policy in it's entirety included; a purpose to provide safe living and working environment free of second-hand smoke and tobacco products. Policy identified no smoking, no use of tobacco products, and no use of electronic cigarettes are allowed in the building or on the grounds of the community. Procedure	2 830		

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2 830	Continued From page 35 identified 1. residents and their responsible parties are notified of the smoke free campus prior to admission. 2. Residents admitted, who have been previous smokers/tobacco users, are supported with smoking cessation including orders from the attending physician. Undated Fire Policy and Procedure directed staff to R-Rescue anyone in immediate danger. A-alert other staff members of the fire and location over the intercom system. Pull the nearest fire alarm. The Person in Charge shall contact the fire department by calling 911. C-contain the fire. E-extinguish if the fire is small. The extinguisher should be aimed low at the base of the fire and move slowly upward with a sweeping motion. The IJ which began on 2/8/24 was removed on 2/9/24 when the facility successfully implemented a removal plan which included: -comprehensively assessing all residents who smoke to include an observation -updating resident care plans with safety interventions. Care plans were individualized for each resident to safely smoke to include: smoking habits, availability of smoking aprons, monitoring for unsafe smoking practices such as burns on body and in clothing... -revised facility smoking policy to include: signing out when going outside to smoke, smoking cessation tools, safe smoking assessments, smoking apron availability, will consult with resident representative RR) or family member (FM) for supervision), attempt to work with resident RR, FM to encourage safe smoking while off campus, and residents who do not follow the safe smoking rules may have smoking materials removed up to a discharge. Educating all residents that the facility is a non-smoking campus, educated resident	2 830		

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2 830	Continued From page 36 representative for residents who are not cognitive and if a resident was deemed not safe to smoke interventions may include providing additional supervision. Educated staff before the next shift on a non-smoking facility, reporting any signs of a resident smoking, immediately notify a supervisor of smoking, how to extinguish fires and educating residents and representatives about not sharing smoking materials. These interventions were verified as having been implemented on 2/9/24 evidenced by a review of observations, documentation and resident and staff interviews who verified education had been completed as outlined. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure residents who smoke not on the smoke-free campus are supervised appropriately for safety. The administrator or designee should also ensure if smoking is allowed, residents are supplied with a smoking receptacle to discard cigarettes. The facility should re-educate all staff identified to policies and procedures, and audit residents who smoke to determine safety and supervision occured. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	2 900		3/12/24

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2 900	Continued From page 37 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to perform timely comprehensive skin assessments, follow physician orders to provide treatment and services to heal and prevent pressure ulcer infection for 1 of 3 residents (R1) reviewed for pressure ulcers. The facility's failure resulted in harm to R1 who developed a stage 4 pressure ulcer with osteomyelitis and associated cellulitis requiring hospitalization. Findings include: Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Stage 3 Pressure Ulcer: Full-thickness loss of	2 900	"Corrected"	

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2 900	Continued From page 38 skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. Stage 4 pressure ulcer: Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle tendon, ligament, cartilage, or bone in the ulcer. Slough and /or eschar may be visible on some parts of the wound bed. Unstageable pressure ulcer: Full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a stage 3 or 4 pressure ulcer will be revealed. Osteomyelitis: an infection in a bone reached by traveling through the bloodstream or spreading from nearby tissue, treatment is usually surgery to remove portions of bone that have died, followed by strong antibiotics. R1's hospital discharge summary dated 12/7/23, identified R1 was hospitalized from 11/30/23 to 12/7/23 for right leg cellulitis (a serious bacterial infection of the skin) with discharge orders for treatment of cellulitis with antibiotics and has four wounds: right knee, right lower leg, left knee and left heel. Orders to clean each wound with wound cleanser, pat dry with sterile 4 x 4 gauze, apply a 4 x 4 border dressing to each wound and change every three days and as needed if dressing becomes soiled. Heel offloading boots to bilateral legs when in bed and wheelchair do not walk in boots.	2 900		

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2 900	Continued From page 39 R1's Skin assessment dated 12/7/23, identified R1 was at risk for pressure ulcers. The assessment did not identify any current pressure ulcers. R1's nurse practioner (NP) progress note, dated 12/8/23, does not identify any pressure ulcer to R1's left heel. R1's progress note dated 12/10/23, identified a skin assessment identified wound on heels had small serosanguinous drainage (mix of red and yellow drainage) not open. Area surrounding very tender, wound cleansed and Mepilex dressing (foam dressing) applied. The assessment did not identify the wound type, a description of wound characteristics, measurements, signs and symptoms of healing, infection or if they had any pain. R1's admission Minimum Data Set (MDS) dated 12/13/23, indicated R1's cognition was intact. R1 had diagnoses of cellulitis of lower right limb, hemiplegia (weakness on one side) and hemiparesis (paralysis on one side) following cerebral infarction (stroke) affecting left non-dominant side, dementia, bilateral hearing loss, and wound infection other than foot. R1 had impairment in range of motion (ROM) in all extremities, was dependent with lower body dressing, required maximal assist with transfers and used a manual wheelchair for mobility. R1 was at risk for pressure ulcers, had a stage 1 pressure ulcer, a pressure reducing device for bed and wheelchair, pressure ulcer care, and applications of dressings to feet. R1's Care Area Assessment (CAA) dated 12/13/23, indicated R1 was at risk for new or	2 900		

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2 900	Continued From page 40 worsening pressure injury related to impaired mobility requiring assist with bed mobility, incontinence, and the use of psychotropic and diuretic medications. R1 had a stage 1 pressure injury, a pressure reducing mattress and wheelchair cushion, bilateral grab bars to assist with bed mobility, pillows utilized for positioning, heels floated in bed, staff to assess skin when providing cares and registered nurse (RN) to perform weekly body audit. R1's care plan dated 12/13/23, identified R1 was at risk for new or worsening skin impairments related to diagnosis of cellulitis in right leg. Prevention interventions dated 12/27/23, directed staff to observe pressure areas daily with cares and report any concerns to the nurse, wound nurse consultant as needed, wound care as ordered, offer turning and repositioning every two hours as needed. Care plan did not address R1's pressure ulcer to the left heel. R1's Skin assessment dated 12/14/23, identified R1 was at risk for pressure ulcers. The assessment did not identify any current pressure ulcers. R1's NP progress note dated 12/19/23, identified an unstageable pressure ulcer to R1's left heel, no complaints of pain, pressure relief measures in place. Plan-in-house wound MD (medical doctor) consult, heel protectors while in bed, and offload pressure. There was no description of the unstageable pressure ulcer including characteristics, measurements, infection, or drainage. R1's wound physician progress note dated 12/20/23, identified R1 to have a stage 3 pressure ulcer to the left heel, 2.9 centimeters	2 900		

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2 900	Continued From page 41 (cm) x 4.7 cm x 0.1 cm, wound bed had 75% granulation tissue and 25% slough with light serous exudate. Treatment order use hydrocolloid sheet (provides a protective, translucent barrier that facilitates granulation and epithelialization. Smooth, satin backing is low friction for longer wear) apply every 3 days, recommend floating heels in bed. No debridement completed due to insignificant amount of necrotic tissue and no signs of infection, monitor closely. The best medical estimate of the wound to heal with continued physician evaluation and intervention is 56 days with 80 % certainty. R1's wound physician progress note dated 12/27/23, identified R1's stage 3 pressure ulcer to the left heel, 0.9 cm x 4.7 cm x 0.1 cm, wound bed had 60% granulation tissue and 40% slough with moderate serous exudate. Treatment order changed to apply foam border dressing (designed to absorb fluid (exudate), and to maintain a moist environment) apply every 3 days, recommend floating heels in bed. No debridement completed due to insignificant amount of necrotic tissue and no signs of infection, monitor closely. Follow up within 7 days. R1's wound physician progress note dated 1/3/24, identified R1's stage 3 pressure ulcer to the left heel, 2.5 cm x 3.0 cm x 0.2 cm, wound bed had 50% granulation tissue and 50% slough with moderate serous exudate. Treatment order changed to apply Medi honey (antimicrobial dressing used to draw fluid from deeper tissues to the wound surface to promote removal of devitalized tissue) with a foam border dressing apply every 3 days, also add skin prep daily, recommend floating heels in bed. No debridement completed due to non-infected heel	2 900		

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2 900	Continued From page 42 necrosis, monitor closely. Follow up within 7 days. R1's nutritional progress note dated 1/5/24, identified skin with unspecified left heel ulcer being monitored by wound clinic and nursing, receiving a multivitamin which should help meet micronutrients needs for healing. R1's NP progress note dated 1/9/24, identified R1's left heel wound was covered with a dressing. R1 had unstageable pressure injury to left heel, followed by in house wound MD. Plan- Medi honey covered with Mepilex (absorbent foam dressing), change daily. There was no description of the unstageable pressure ulcer including characteristics, measurements, infection, or drainage. R1's wound physician progress note dated 1/10/24, identified R1's appointment was rescheduled due to being at an outside appointment. Review of record identified R1's left heel wound was not comprehensively assessed from 1/3/24 to 1/17/24 a total of 14 days. R1's NP progress note, dated 1/15/24, identified R1's left heel wound was covered with a dressing. R1 had no complaints of pain, pressure relief measures in place, facility wound MD following R1. Plan- weekly wound rounds, Medi-honey to left heel cover with Mepilex, daily dressing change, heel protectors while in bed, and offload pressure. There was no description of the pressure ulcer including characteristics, measurements, infection, or drainage. R1's January 2024 treatment administration record (TAR) identified on 1/14/24, R1's left heel dressing was not completed due to dressing was	2 900		

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2 900	Continued From page 43 not saturated, even though the physician's order identified Medi-honey to left heel with Mepilex dressing daily. R1's wound physician progress note dated 1/17/24, identified R1's pressure ulcer to the left heel advanced to stage 4, measured 2.8 cm x 3.6 cm x 0.3 cm, wound bed had 50% granulation tissue and 30% slough and 20% thick adherent devitalized necrotic tissue, exacerbated due to infection, with a moderate amount of serous exudate. Concerned with worsening heel wound and superficial infection labs ordered. Treatment order changed to apply foam border with silver dressing (used to treat infected wounds due to antimicrobial properties) apply every 3 days, also add skin prep daily, recommend floating heels in bed. Debridement completed due to increased necrosis with removal of 4.26 cm of devitalized and necrotic muscle level tissues as a result the nonviable wound bed tissue decreased from 50% to 10%. Monitor closely. Follow up within 7 days. R1's physician orders 1/17/24, and January 2024 Treatment Assessment Record (TAR) did not identify the new treatment order to apply foam dressing with silver. The record identified R1's wound was treated with Medi honey dressing until 1/26/24, causing R1 to miss 10 days of physician ordered treatment of silver dressing. R1's progress note dated 1/17/24, identified R1's left heel pressure ulcer was not improving; wound care provider recommends - Ankle Brachial Index (ABI) test (a simple test that compares the blood pressure in the upper and lower limbs used to determine reduced blood flow) to test blood flow to the area. R1's TAR 1/18/24, included R1's left heel wound	2 900		

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2 900	Continued From page 44 was not healing. The TAR on 1/23/24, included odor to wound noted. R1's NP progress note dated 1/23/24, identified left heel unstageable pressure ulcer being followed by facility wound MD, per report not healing, faint odor. Plan- ABI appointment pending, Registered Dietician (RD) consult, add Juven (a collagen supplement used to promote wound healing) twice a day, offload pressure and heel protectors. R1's nutritional progress note dated 1/23/24, identified stage 2 pressure ulcer to the left heel being monitored by wound specialist and nursing, recently noted to be declining, had been receiving a multivitamin but no additional nutritional support related to good intake and appetite. After discussion with NP and reported decline in wound will begin Juven 1 packet twice a day. R1's wound physician progress note dated 1/24/24, identified R1's stage 4 pressure ulcer to the left heel, 5 cm x 4 cm x 0.3 cm, wound bed had 70% granulation tissue and 30% slough with moderate serous exudate. Treatment order foam border dressing with silver dressing apply every 3 days, add skin prep daily, and recommend float heels in bed. No debridement completed due to non-infected heel necrosis, monitor closely. Follow up within 7 days. R1's progress note dated 1/24/24, identified R1 was seen by "wound provider" left heel odor has decreased, doppler showed blood flow to the area, has been using Prevalon heel boots, will attempt to float heels using two pillows when in bed and chair instead of heel boots. R1's progress note dated 1/26/24, identified	2 900		

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2 900	Continued From page 45 meeting with R1 and family to discuss left heel healing status, family wondered if a culture of the wound could be completed to see if R1 would need an antibiotic. R1's TAR dated 1/16/24, included wound culture to left heel performed. Per interview on 2/14/24 at 4:16 p.m. the wound doctor reported the wound culture showed proteus mirabilis. R1's NP progress note dated 1/30/24, identified R1's left heel wound edges to be macerated (skin softening and breaking down due to prolonged contact with moisture), center of wound slough, moderate drainage. Followed by in house wound MD, wound culture obtained, white blood count (WBC) 11.2 (anything above 11 can be related to infection). Plan-vascular appointment 2/7/24, RD following, Juven twice a day, weights two times weekly, offload pressure and heel protectors. R1's wound physician progress note dated 1/31/24, identified R1's stage 4 pressure ulcer to the left heel, 5.6 cm x 7.3 cm x 0.4 cm, wound bed had 50% granulation tissue and 50% slough with heavy serous exudate. Wound was exacerbated and treatment order changed to apply Medi honey with foam border dressing with apply daily with skin prep, recommend float heels in bed. Debridement completed due to the need to remove necrotic tissue and establish viable margins of viable tissue, 16.35 cm of devitalized tissue including slough, biofilm and non-viable tissue in the wound bed decreased from 50% to 10 %. Monitor closely and follow up within 7 days. R1's progress notes dated 1/31/24, wound provider rounds family present and educated on wound status and recommendations, stated R1's heel was making slight improvement. X-ray ordered to rule out osteomyelitis.	2 900		

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2 900	Continued From page 46 R1's progress note dated 2/1/24, identified left heel X-ray results impression was a large posterior heel ulcer and underlying posterior calcaneal osteomyelitis (inflammatory condition of the bone secondary to infection). Nurse practitioner (NP) was paged with results and gave orders to send to the hospital with the new diagnosis of osteomyelitis. R1's emergency department (ED) to hospitalization progress notes dated 2/1/24 to 2/14/24, identified R1 was admitted for treatment of left heel osteomyelitis with associated cellulitis. As of 2/14/24, R1 was still hospitalized. During an interview on 2/12/24 at 1:07 p.m., family member (FM)-B stated R1 admitted to facility with a left heel blister and was planning to move to an Assisted Living facility (ALF) and ALF staff came to evaluate R1. R1 was admitted to hospital on 2/1/24 with an unstageable pressure ulcer with osteomyelitis and was on three different antibiotics and would not return to the facility after hospitalization. FM-B stated "It took our family being aggressive for the facility to do anything about R1's infected left heel." During an interview on 2/12/24, at 3:06 p.m., DON indicated the admission floor nurse was responsible to remove dressings, assess and measure wounds during an admission. DON identified R1's pressure ulcer to left heel was not comprehensively assessed from admit date of 12/7/23, until the wound doctor came onboard on 12/20/23. Additionally missed a comprehensive assessment on 1/10/24 and verified the pressure ulcer went from a stage 3 to a stage 4. The assessment should include wound bed and peri wound description, measurements, signs and	2 900		

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2 900	Continued From page 47 symptoms of infection, and drainage and to document this weekly. DON identified being wound certified and would expect a wound to be larger when Medi-honey was used. Skin assessments should be done on admission, weekly for the first four weeks, quarterly and with all significant changes. R1 had weekly wound rounds by the wound physician, if the wound physician was not available it would be the responsibility of the floor nurse to assess the wound and document it. During a phone interview on 2/12/24 at 4:16 p.m., wound doctor (WD)-A indicated a comprehensive wound assessment should be completed weekly to identify changes to help with the treatment plan for healing. WD-A stated that an addendum was made to R1's chart after a phone conversation with the DON. WD-A stated that an odor was present in the wound on 1/24/24 and discussed the need for topical antibiotics and the next week on 1/31/24 the odor was less prominent, acknowledged that R1 was hospitalized with osteomyelitis to the left heel on 2/1/24. WD-A indicated he was under the impression that nursing assistants or licensed nursing staff were completing dressing changes. WD-A did feel that the wound was getting worse on the last visit (1/31/24) but that wound measurements were not always completed and WD-A admitted to sometimes "eyeballing" the wounds instead of measuring. WD-A stated that the only reason he ordered the x-ray was because the family was insistent on further testing. During an interview on 2/13/24 at 12:39 p.m., medical director (MD)-A stated, I expect wound assessments to be done on a weekly basis to determine an appropriate treatment for healing or maintaining a pressure ulcer. MD-A indicated the	2 900		

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2 900	Continued From page 48 facility had completed some weekly assessments and missed some others. MD-A stated the facility began working with a contracted wound care company in December 2023 as facility wounds had not been properly managed and had thought things were getting better. Facility policy, "Prevention and Treatment of Skin Breakdown/Pressure Injury," dated 2018 identified a Purpose: Maintaining intact skin is integral to resident health and wellness. Care and service are delivered to maintain skin integrity and promote skin healing if skin breakdown should occur. Policy: Resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission, weekly for 4 weeks, upon significant change and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reducing the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care. 3. Skin integrity is monitored, and abnormal findings are documented: o Skin is observed daily with cares. If any skin concerns are noted, they are reported to the licensed nurse. o Weekly skin audits are performed by a licensed nurse. 4. A therapy evaluation is requested as appropriate. 5. Education is provided to the resident/resident representative as indicated. II. Treatment of impaired pressure injury and lower extremity ulcers (arterial, venous, neuropathy/diabetic, or mixed). If a resident is admitted with impaired skin integrity or new pressure injury or a lower extremity ulcer develops, the licensed nurse implements the follow items: 1. Documentation of the skin impairment is completed in the medical record. Staging is completed as necessary by	2 900		

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2 900	Continued From page 49 trained licensed nursing associates. 2. Standing orders/protocol for skin impairment are initiated. 3. Notify attending provider, resident, and resident representative. Attending provider determines wound type and may provide additional orders. 4. Notify Supervisor/designee. 5. Evaluate current pressure reduction interventions and revise resident centered care plan. 6. Notify dietitian for nutritional interventions. 7. Notify therapy associates and other members of the care team as appropriate for possible additional treatment interventions. 8. Educate resident/resident representative on skin impairment and care plan interventions. 9. When pressure injury is present, the dressing and/or wound as appropriate are monitored daily. 10. Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If wound bed has deteriorated; notify attending provider. 11. Notify the attending provider, resident/resident representative, and supervisor if the skin injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce	2 900		

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2 900	Continued From page 50 the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure medications were available for administration per physician order for 2 of 3 residents (R2 and R8) reviewed for resident safety. Findings include: R2's admission Minimum Data Set (MDS) dated 1/24/24 identified R2 to have intact cognition and and did not identify if tobacco was used. R2's provider note dated 1/19/24, identified R2 was a pack a day current smoker, will add Nicotrol inhaler for tobacco abuse. R2's provider note dated 1/23/24, identified R2 was a pack a day current smoker, Nicotrol inhaler	21550	"Corrected"	3/12/24

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21550	Continued From page 51 for tobacco abuse was ordered supply has not arrived from the pharmacy. R2's January 2024 medication administration record (MAR), identified Nicotrol (nicotine) cartridge; 10 milligrams (mg) give every two hours as needed; puff for 20 minutes per cartridge. The MAR identified Nicotrol inhaler was not administered between 1/19/23 to 1/23/24. Corresponding nursing notes identified the medication was not given because the medication was not available. On 1/24/24 and 1/25/24 Nicotrol nasal spray non-aerosol; 10 mg/milliliter (ml) give a spray to nostril every hour as needed may repeat one spray if not effective. The MAR identified Nicotrol spray was not administered between 1/24/23 to 1/25/24. Corresponding nursing notes identified the medication was not given because the medication was not available. During an interview on 2/7/24 at 4:07 p.m. director of nursing (DON) reviewed R2's record and confirmed R2's Nicotrol inhaler or spray was not made available while at the facility due to problems with getting the medication from the pharmacy. R8's significant change (MDS) dated 1/31/24 identified R8 to have intact cognition and diagnoses of prostate cancer and a urinary tract infection (UTI) in the last 30 days, had an indwelling catheter and was currently receiving antibiotics. R8's December 2023 MAR, identified Bactrim (antibiotic medication) with a start date of 12/15/23 to 1/10/24. The MAR further identified Bactrim was not administered on 12/30/23 due to medication not available.	21550		

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21550	Continued From page 52 R8's provider note dated 1/9/24 identified R8 was having hematuria (blood in urine), generalized weakness and positive urine culture to treat UTI with Cipro (antibiotic medication) 250 mg twice a day for seven days. R8's provider note dated 1/15/24 identified R8's Cipro course for UTI will be completed tomorrow on 1/16/24 and to resume Bactrim per urology orders after Cipro was completed. R8's physician orders included give Bactrim 400-80 milligrams (mg) every day for UTI prophylaxis per urologist (start date 1/22/24 with no stop date). R8's January 2024 MAR, identified the aforementioned physician orders with a start date of 1/22/24 to 2/8/24. The MAR further identified Bactrim was not administered on 1/23/23 due to medication not available, unable to find. R8 missed seven doses of Bactrim between 1/17/24 to 1/23/24 there was an 'X' (indicating not given) placed in dates from 1/17/24 to 1/22/24. Cipro was not documented as given from 1/9/24 to 1/16/24 with 14 missed doses. During an interview on 2/12/24 at 2:04 p.m. director of nursing (DON) indicated doses of R8 antibiotics were not documented as given as ordered. DON's stated medications should be available to be given as ordered by the prescriber. During a phone interview on 2/13/24 at 12:43 p.m. medical director (MD)-A stated any prescribed medication to a resident should be available to the resident within 24 hours, if it's an antibiotic we would want it sooner than that.	21550		

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(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
21550	Continued From page 53 Facility policy Pharmacy Services dated 12/17, identified ... 7) Providing routine and timely pharmacy service as contracted and emergency pharmacy service 24 hours per day, seven days per week. b. All other new medication orders are received and available for administration on the next routine delivery, unless indicated otherwise by facility staff. Medications will be delivered by the primary pharmacy or back-up pharmacy or are available from the electronic medication cabinet (EMC) or emergency medication kit ... 13) Implementing procedures when medication delivery was delayed, or medications are not available. Facility policy unavailable medications dated 12/17, policy identified medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. Procedures: A. The pharmacy staff shall: 1) Call or notify nursing staff that the ordered product(s) is/are unavailable. 2) Notify nursing when it is anticipated that the drug(s) will become available. 3) Suggest alternative, comparable drug(s) and dosage of drug(s) that is/are available, which is covered by the resident's insurance. B. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00459	A. BUILDING: _____ B. WING _____	C 02/12/2024

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21550	Continued From page 54 Facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medication. 3) Notify the pharmacy of the replacement order. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21550		