DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 17BP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00568

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245090**
2.STATE VENDOR OR MEDICAID NO.
(L2) **270543500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PLEASANT MANOR LLC**
(L4) **27 BRAND AVENUE**
(L5) **FARIBAULT, MN** (L6) **55021**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/01/2018**

6. DATE OF SURVEY **06/29/2020** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **65** (L18)
13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 06/29/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 06/29/2020 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/21/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
06201 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
04/02/2020 (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 6, 2020

CMS Certification Number (CCN): 245090

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 3, 2020 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered

July 6, 2020

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

RE: CCN: 245090
Survey Start Date: January 28, 2020

Dear Administrator:

On June 29, 2020 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 3, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 17BP

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(L3) **PLEASANT MANOR LLC**
(L4) **27 BRAND AVENUE**
(L5) **FARIBAULT, MN** (L6) **55021**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/01/2018**

6. DATE OF SURVEY **01/29/2020** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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13.Total Certified Beds **65** (L17)

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE — Date :
Sarah Grebenc, Unit Supervisor — 03/17/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 04/02/2020 (L20)

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3. Both of the Above :
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01/21/1967
(L24)

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(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 6, 2020

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

RE: 245090
Cycle Start Date: January 29, 2020

Dear Administrator:

On January 29, 2020, a survey was completed at your facility by the Minnesota Department(s) 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 18, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 18, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 18, 2020.

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

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

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Pleasant Manor LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 18, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Phone: (651) 201-3792 Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 29, 2020 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements was conducted on January 29, 2020 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based	E 039		3/20/20

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

Electronically Signed | 03/13/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 1 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 2 exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 3 questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or	E 039		

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E 039	Continued From page 4 prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039		

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E 039	Continued From page 5 emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and	E 039		

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E 039	Continued From page 6 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a community based, full scale exercise and/or a table top exercise was completed annually to test their emergency preparedness plan. This had the potential to affect all 50 residents resided in the facility. Findings include: During interview with Corporate Nurse Consultant (CNC) on 1/28/20, at 2:00 p.m. CNC	E 039	The facility will conduct an EP Exercise to test the emergency plan at least two (2) times per year which will be unannounced. This exercise will include the following: 1. A Table Top Exercise will be conducted by March 20, 2020. 2. The facility will participate in the 2020 community or statewide emergency mock disaster drill. The EP Exercises will be facilitated and	

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E 039	Continued From page 7 verified a community based and/or table top exercise had not been performed in 2019 with facility staff. When interviewed on 1/28/20, at 3:49 p.m. maintenance director confirmed the facility had not conducted and documented an emergency preparedness community based and/or table top exercise in the last year. Maintenance director stated the last emergency preparedness exercise had been completed in 2018. A facility policy was requested, and not made available.	E 039	monitored by the Administrator and Maintenance Director	
F 000	INITIAL COMMENTS On 1/27/20 to 1/29/20, a standard survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not found to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated with tags: H5090048C H5090051C Deficiency issued at F732 H5090052C Deficiency issued at F609 The following complaints were found unsubstantiated: H5090049C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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	Past noncompliance: no plan of correction required.	

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F 000	Continued From page 8 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.	F 567		3/20/20

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F 567	Continued From page 9 (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide ready access to trust funds for 1 of 1 resident (R36) reviewed for personal funds. This had the potential to affect 21 residents who had personal funds in the trust account with the facility. Findings include: R36 reported during interview on 1/27/20, at 2:34 p.m. that every time she asked for money from her trust account facility staff told her they had no cash available. R36 also stated there was no cash available on weekends. R36's annual Minimum Data Set assessment dated 12/27/19, indicated R36's cognition was intact. Licensed practical nurse (LPN)-C was interviewed on 1/28/20, at 10:21 a.m. there used to be a cash box kept for residents who requested withdrawals of cash after business hours. LPN-C stated now if a resident requested money on the weekend, LPN-C would ask the	F 567	A cash box was set up for resident trust fund withdrawals for after hours and on weekends once this infraction was identified. The policy and procedure for trust fund withdrawals during off hours was revised to include evenings and weekends. The Nursing and IDT Team were educated on the trust fund cash withdrawal revised policy. Residents were provided information on the trust fund cash withdrawal revised policy. Audits of the new trust fund withdrawal process with resident interviews will be conducted weekly x4 then monthly x2 to assure residents are able to withdraw cash should they need it after normal business office hours. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. This will be monitored by the Administrator.	

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F 567	Continued From page 10	F 567		

resident if they really needed it or if they could wait until Monday.

When interviewed at 10:22 a.m. on 1/28/20, LPN-D stated residents can only get cash from their trust account if someone has access to the business office. LPN-D stated the business office was open only on Monday through Friday during business hours, or residents could ask the administrator. LPN-D stated if a resident asked for cash withdrawal from their trust account after hours she would tell the resident they do not have access to the money and the resident would have to wait until Monday.

R36 stated during interview 1/28/20, at 11:09 a.m. she had resided at the facility for a year and in that time there were times where she was not able to get money out of her account on the weekends and also not able to get money during the week. R36 stated she had asked the administrator for a cash withdrawal of $56.00 from her trust account on Monday (1/27/20) and was told there was no cash available and that he needed to go to the bank. R36 stated she asked the administrator 4-5 times that day and was told he didn't have time and needed to find someone to go to the bank for him. R36 stated she had told the office manager in December she would like all of her check cashed when it came in on the 3rd or 4th each month but this had not done. R36 stated she usually signed her own check until the last couple months when business office manager told her the administrator had signed her checks and was told he deposited it in her trust account. R36 stated she had asked over the last weekend for $25 from her trust account and was told to wait until Monday (1/27/20). R36

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F 567	Continued From page 11 stated she still had not yet received any cash withdrawal from her trust account on Tuesday (1/28/20). The administrator stated during interview on 1/28/20, at 3:04 p.m. that residents needed to have access at all times to their trust accounts. The administrator stated the business office manager was on leave and no one had replaced her. The administrator stated R36 had $28.66 balance in her trust account on 1/13/20, and confirmed he'd given her $20 today on Tuesday (1/28/20) and now has balance $8.66. The facility's Resident Trust Fund policy dated 11/25/15, indicated the purpose was to allow residents to withdraw personal funds as needed. The policy indicated residents could receive withdrawals from the trust account 7:00 a.m. to 3:00 p.m. on Monday through Friday up to $50.00.	F 567		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced	F 568		3/20/20

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F 568	Continued From page 12 by: Based on interview and document review, the facility failed to provide balance in trust account and written statements for 1 of 1 resident (R36) reviewed for personal funds. This had the potential to affect 21 residents who had a trust account with the facility. Findings include: R36 stated on 1/28/20, at 11:09 a.m. that she had told the office manager in December she would like all of her check cashed when it came in on the 3rd or 4th of each month but was not done. R36 stated she usually signed her own check until the last couple months when business office manager told her the administrator had signed her checks and was told he deposited it in her trust account. R36 stated she would like to know her balance and would like a statement which she never received. R36's annual Minimum Data Set, dated 12/27/19, indicated R36's cognition was intact. During interview with the administrator on 1/28/20, at 3:04 p.m. it was verified residents with trust accounts were not provided statements and did not get the applicable interest distributed to them. The administrator verified R36's statement dated 4/23/19, through 1/13/20, with balance as high as $248.00 had not received any interest on her account. Facility policy Resident Trust Fund dated 11/25/15, indicated the purpose was to allow residents to withdraw personal funds as needed. The policy did not indicate applicable interest	F 568	Resident #36 was given a statement of her trust fund account. Resident #36 will receive cash should she desire each month when her check arrives at the facility. All residents with trust funds will receive applicable interest and quarterly statements. The Policy for Resident Trust Fund was revised to include quarterly statements as well as applicable interest being applied. The ID Team and Nursing staff were educated on the revised Resident Trust Fund procedures. Audits of 5 resident trust fund accounts will occur weekly x4 then monthly x2 to assure statements are being provided and applicable interest being applied. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. This will be monitored by the Administrator	

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F 568	Continued From page 13 would be paid out to each resident in the trust fund nor did it indicate residents would be given written statements.	F 568		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of abuse	F 609	Re-education was provided to nursing leadership on the need for timely	3/20/20

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F 609	Continued From page 14 was reported to the administrator and State agency (SA) in a timely manner for 1 of 2 records reviewed for abuse. Findings include: A facility incident reported dated 1/2/20, indicated trained medical assistant (TMA)-A allegedly saw the director of nursing (DON) take medication on 12/30/2019. The TMA-A reported this to TMA-B on 1/1/2020 (2 days later). The assistant director of nursing (ADON) was called on 1/1/20, and came to the facility to investigate, called the human resource director (HRD) and notified the Administrator immediately. During an interview on 1/28/20, at 3:03 p.m. the ADON stated the previous DON did take medications. The ADON stated they also found 6 oxycodone had been taken from the EKit. Per the ADON the facility reported the incident, but further investigation confirmed no residents were missing any prescribed medications. The ADON acknowledged they could have investigated sooner if the TMA-A had reported it right away. The TMA-A was educated on 1/1/20, about reporting in a timely manner. On 1/28/20 03:23 p.m. the Administrator stated a staff member had seen the DON take 3 tablets from R15's Trazadone out of the transitional care unit (TCU) 300 cart on 12/30/2019. The DON was placed on suspension on 1/1/20, and was terminated on 1/3/20. The facility also determined the E-kit had been opened on 12/14/19, with 6 tablets of Oxycodone removed and not accounted for on the medication administration record (MAR) or administrated to any residents.	F 609	reporting of allegations due to an allegation identified that was reported 24 hours later than the Policy directs. The Abuse Prevention / Vulnerable Adult Policy was reviewed and remains current. All allegations will be reported timely. All staff will be re-educated on the need for timely reporting of allegations. All allegations will be audited to assure timely reporting occurs according to the Abuse Prevention Policy. This will be an ongoing process with results shared monthly with the facility QAPI Committee. This will be monitored by the Administrator.	

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F 609	Continued From page 15 Further, they confirmed there were no residents that missed their prescribed medication on 12/14/19. All nurses and TMA's were interviewed regarding the investigation. Through the investigation, it was found out the only witness to the event was TMA-A. It was reported to SA, broad of nursing and the police were called on 1/1/20. The administrator stated the ADON went through re-education with nurses about medications, med carts and reporting on time on 1/1/20. The facility Abuse prevention/Vulnerable Adult Plan reviewed/revised on 7/2018, directed, "Suspected Abuse shall be reported to Office of Health Facility Complaints [OHFC] online reporting process not later than 2 hours after forming the suspicion of abuse. Suspicion of neglects, exploitation, or misappropriation of resident property must be reported to OHFC online reporting process not later than 2 hours if the incident resulted in serious bodily injury."	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		3/20/20

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F 657	Continued From page 16 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for 1 of 1 residents (R13) reviewed to reflect the most recent quarterly assessment of care needs. Findings include: R13's quarterly Minimum Data Set (MDS) dated 11/15/19, indicated R13 had moderate cognitive impairment, extensive assist of one for transfer (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position), extensive assist of one for toilet use, and not steady, only able to stabilize with staff assistance for surface-to-surface transfer (transfer between bed and chair or wheelchair) and transfer on and off toilet. R13's MDS further indicated diagnoses including chronic obstructive pulmonary disease (COPD-a medical condition that causes shortness of breath, chronic cough, and wheezing), heart disease, and respiratory failure.	F 657	Resident #13's Care Plan was revised to accurately reflect her assessed care needs. The Policy for revising Care Plans was reviewed and remains current. The ID Team and licensed nurses will be re-educated on the need to revise care plans as resident care needs change. All resident Care Plans will be reviewed and revised if needed to assure they are a current reflection of the care needs. 5 Care Plans will be audited weekly x4 then monthly x2 to assure they are reflective of the resident's current care needs. The results of these audits will be shared with the facility QAPI Committee for input of the need to increase, decrease or discontinue the audits. This will be monitored by the Nurse Managers and MDS Coordinator.	

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F 657	Continued From page 17 R13's care plan indicated R13 had a self-care performance deficit related to history of falls with neck fracture, with the intervention dated 10/3/17, that R13 was independent with toilet use, and to assist as needed/requested. The care plan further indicated R13 has limited physical mobility with high falls risk, and intervention dated 2/27/17, indicated R13 was independent with transfers, and intervention dated 4/25/17, indicated to use assistive device and one staff assist as needed getting in and out of bed with transfers. On 1/28/20, at 10:42 a.m. family member (FM)-C stated R13 did not receive appropriate care, had declined over recent months and staff did not provide the needed assistance to her and treated R13 as independent with ADL's. FM-C further stated she felt R13 would be dead by now if she wasn't there to help and watch over her. During an interview on 1/28/20, at 10:46 a.m., R13 stated if she had to wait too long for assistance, she would get up and go to the bathroom on her own. On 1/28/20, at 2:37 p.m., Nursing Assistant (NA)-A was interviewed and stated R13 frequently used the restroom, but would put her call light on if help was needed and was "pretty independent." On 1/28/20, at 4:01 p.m., Registered Nurse (RN)-A was interviewed and stated R13 moved in the room independently and would ask for help if needed.	F 657		

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F 657	Continued From page 18 During an observation on 1/29/20, at 8:06 a.m., R13 sat in her recliner, with a nebulizer (breathing treatment) running. R13 verbalized she self-transferred to chair to self-administer nebulizer treatment. During an interview on 1/29/20, at 8:23 a.m., NA-B stated R13 always transferred herself from the bed and was independent for toileting. NA-B further indicated during her orientation, she learned that R13 was very independent. During an interview on 1/29/20, at 10:25 a.m., licensed practical nurse (LPN)-A stated R13 was mostly independent in room. She would call for help if needed. During an interview on 1/29/20, at 11:30 a.m., the assistant director of nursing (ADON), verified the care plan should match the info on the MDS. During a phone interview on 1/29/20, at 2:52 p.m., the MDS coordinator stated R13 was assessed in person and through staff interviews. The MDS further stated the nurse manager transferred MDS information onto the care plan quarterly or as needed. R13's nursing progress notes were reviewed and the following were noted: -on 10/15/19, at 9:01 p.m., the progress note indicated R13 unhooked tubing and removed oxygen from face many times during the shift, was very confused and unsure of what to do next. -on 10/6/19, at 7:46 p.m., the progress note indicated R13 continued to be confused at times and asked questions "as if she did not know what	F 657		

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F 657	Continued From page 19 she was doing and was unsure of ADLs." The facility's care plan policy revised June 2019, was reviewed and indicated care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy further indicated the care plan is to be modified and updated as the condition and care needs of the resident changes.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate personal cares for 2 of 7 residents reviewed. R24 did not receive scheduled baths and R42 did not get receive adequate oral care. Findings include: R24 was interviewed on 1/27/20, at 6:18 PM. During the interview a musty odor was detected in the room. R24 stated he had not received a shower for 2 weeks. R24 said he would like to have a shower two times per week. Nursing Assistant (NA)-G was interviewed on 1/28/20 9:52 AM. NA-G explained R24 was scheduled for a shower on 1/28/20, but had an appointment so he requested and got a shower last night. NA-G explained each time a shower	F 677	R24 received a shower and R42 received assistance with oral care. The Policy for ADL care was reviewed and remains current. All residents will receive necessary assistance with ADL care. All nursing staff will be re-educated on the ADL Care Policy to include documenting refusals. Recurrence will be prevented by visual audits of 5 residents to assure assistance is provided with showers and oral care will occur weekly x4 then monthly x2. The results will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. This will be monitored by the Nurse Managers.	3/20/20

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F 677	Continued From page 20	F 677		

was given the NA's completed a written form called the weekly skin inspection, and would give the completed form to the nurse to enter the information into the electronic health.

A medical record review for R24, completed on 1/28/20, of the Weekly Skin Inspection documentation indicated a weekly skin inspection occurred on the following dates:
1/24/20, did not indicated a shower was given (nothing checked) nails were not trimmed, not shaved.
1/13/20, indicated shower received, Nails not trimmed, not shaved.
12/20/19- shower given, nails were not trimmed, not shaved.

The documentation showed a lapse of 24 days between showers from 12/20/19 to 1/13/20, and 11 days between showers from 1/13/20 to 1/24/20. The record lacked indication R24 had refused showers.

R42's annual Minimum Data Set (MDS) dated 1/10/20, identified R42 had moderate cognitive impairment and diagnoses that included heart failure, dementia, fibromyalgia and hallucinations. The MDS indicated R42 required extensive assist of one for personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands).

R42's care plan (revision dated 2/21/19) indicated resident had a self-care deficit related to heart failure, edema, fibromyalgia and other diagnoses with interventions that included: assist with bathing, transfers, dressing and personal

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F 677	Continued From page 21 hygiene. On 1/27/20, at 2:39 p.m., R42 was interviewed and stated staff do not help her to brush her teeth. R42's teeth appear dirty with white debris. R42 indicated she would like more help with to brush her teeth and other ADL's in morning and at bedtime. On 1/28/20, at 9:36 a.m., nursing assistant (NA)-C entered R42's room and, along with NA-D, and assisted R42 with incontinence cares and washed R42's face and underarms, applied deodorant, placed R42's eyeglasses, and provided water. Oral care was not offered. R42 was interviewed on 1/28/20, at 10:03 a.m. and stated her teeth have not been brushed and further stated she would like them brushed at least once per day. A dry toothbrush along with toothpaste tube were visible in a plastic basin in the drawer of R42's bedside nightstand. On 1/28/20, at 10:16 a.m., trained medication assistant (TMA)-C was interviewed and stated R42 needs help with ADL's. TMA-C further stated R42 can brush her own teeth once set up, and does not usually refuse cares. On 1/29/20, at 10:19 a.m. licensed practical nurse (LPN)-A was interviewed and stated NA's perform ADL's for R42. LPN-A further stated oral care should be included with ADL cares. On 1/29/20, at 11:42 a.m., the assistant director of nursing (ADON) was interviewed and stated it would be her expectation that NA's would perform oral care to a resident that needed	F 677		

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F 677	Continued From page 22 assistance with ADL's. The facility ADL's policy, revised March 2018, indicated appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, develop or revise, interventions for 1 of 1 resident (R23) reviewed with a pattern of bruising and skin tears. Findings include: R23's admission record, printed 1/29/20, listed diagnoses of post-polio syndrome and hemiplegia/hemiparesis following cerebral infarction affecting right dominant side (paralysis of one side of the body after a stroke).	F 684	Resident #23 was reassessed for patterns of bruises and skin tears and interventions to reduce revised. The Accidents and Incidents Policy was reviewed and remains current. All licensed nurses will be re-educated on the Accidents and Incidents Policy. All residents with a history of a pattern of bruises or skin tears will be reviewed to assure the interventions to prevent are current. Recurrence will be prevented by audits of 5 residents with patterns of bruising or skim tears or new bruising/skin tears will	3/20/20

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F 684	Continued From page 23 R23's admission Minimum Data Set (MDS) dated 9/18/19, identified R23 had intact cognition as indicated by a Brief Inventory of Mental Status (BIMS) score of 15. R23 required extensive assist with activities of daily living (ADLs). R23 was at risk for pressure ulcers but did not have any. R23 had venous stasis ulcers present. R23's corresponding Care Area Assessment (CAA) indicated R23 triggered for ADLs due to decline in mobility following multiple hospitalizations. R23 choose hospice. Plan to continue to assist R23 with ADLs. Additionally, R23 was noted to trigger for pressure ulcer/injury. R23 had several venous ulcers to bilateral lower extremities. Preventative skin measure in place included toileting and repositioning every two hours, pressure redistribution cushion in wheelchair and mattress to bed, routine skin cares every morning and bedtime and weekly skin inspections. R23's care plan with (revision date 9/6/19) identified R23 had alteration in skin integrity related to hematomas and venous ulcers of lower extremities. Interventions included: staff to transfer carefully and slowly to reduce risk of skin tears, weekly wound inspections, wound treatments done and as ordered by the physician or nurse practitioner. R23 had an active prescriber's order dated 9/25/19: Weekly skin inspection by licensed nurse. Complete MHM (Monarch Healthcare Management) weekly skin inspection in PCC (Point Click Care: computerized charting system) in the evening every Monday.	F 684	be completed weekly x4 then monthly x2 to assure they are assessed and interventions are initiated or in place which are appropriate. The results of the audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. This will be monitored by the Nurse Managers.	

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F 684	Continued From page 24 Facility documents titled Weekly Skin Inspection, Weekly Non Pressure Wound or Skin Alteration Evaluation and Incident Review and Analysis identified the following: 9/5/19- Weekly Non Pressure Wound or Skin Alteration Evaluation: Left anterior shin hematoma 8.2 cm. (centimeter) x 6 cm. Left distal lower leg venous ulcer 1.1 cm. x 1.8 cm. Left lower leg venous ulcer. 0.8 cm. x 1 cm. Left posterior calf skin tear 2.8 cm. x 3 cm. Right lateral calf venous ulcer. 1.2 cm x 1 cm. Right posterior calf venous ulcer 1.2 cm x 0.7 cm. 9/19/19- Weekly Non Pressure Wound or Skin Alteration Evaluation: Left anterior shin 7.5 x 5. Left posterior shin 3.8 x 1.8. Left distal leg venous 0.8 x 0.8. (cm. or inches not indicated for these measurements). The evaluation lacked additional information regarding the previous wounds on right lower leg. 9/30/19- Weekly Skin Inspection: Chest was red and rashy, cleansed, dried well, powder applied. The inspection lacked additional information. 10/3/19- Weekly Non Pressure Wound or Skin Alteration Evaluation: Right elbow skin tear 1 x 1.8 (cm or inches not indicated) with scant drainage. Left anterior shin skin tear with scant drainage. Left posterior shin skin tear and left distal leg, venous = healed. The evaluation lacked additional information regarding the cause of the skin tear. 10/10/2019- Weekly Non Pressure Wound or Skin Alteration Evaluation: Right elbow epithelial tissue 0.8 x 0.5. Left lower leg (front) superior	F 684		

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F 684	Continued From page 25 0.7 x 0.9 both are superficial inferior 0.7 x 0.8. Left lower leg (front) superior 0.7 x 0.9 (cm or inches not indicated for these measurements). There were no weekly skin assessments documented after 10/10/19 until 11/25/19. Progress note review showed R23 remained in the facility during this time frame. There was no documentation of R23 refusing weekly skin assessments. 11/25/19 Weekly Skin Inspection indicated rash on the chest, coccyx has blanchable redness. No other wounds or skin conditions were noted. There were no weekly skin assessments documented after 11/25/19 until 1/10/2020. Progress note review showed R23 remained in the facility during this time frame. There was no documentation of R23 refusing weekly skin assessments. R23 had an order with start date of 1/5/20 for "left lower leg- cleanse daily with water and non cytotoxic wound cleanser, cover with non-adherent dressing, secure with kerlix and tape, one time a day for wound care, continue until healed." 1/10/20- Weekly Skin Inspection: Right knee front 5 cm x 2 cm. Right knee outer 4 cm x 2 cm. Right leg 2 cm x 1 cm scab. Right leg 3 cm x 2 cm. Right lower leg 4 cm x 4 cm. Front left leg 7 cm x 4 cm. Left inner leg 9 cm x 2.5 cm skin tear, wound cleaned new steri strip applied to wound,dressing applied. Right arm upper 9.5 cm x 15 cm. Right arm has multiple tiny bruises. The assessment had not indicated what the	F 684		

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F 684	Continued From page 26	F 684		

measurements corresponded with (i.e.. bruises or skin tears). The assessment lacked additional information including any causes and if care planned interventions were developed.

Incident Review and Analysis completed on 1/22/20, showed an incident date of 1/1/20, at 2045 (8:45 p.m.) R23 had a skin tear from transferring. Factors were fragile skin. Care plan was updated to include being cautious and moving R23 slowly to avoid further skin tears. The incident review lacked additional information regarding the cause of the skin tear.

An order on the electronic medical administration record (EMAR) dated 1/22/20 indicated: wound on left arm, clean with normal saline and cover with nonadherent dressing, one time a day for wound on left arm.

On 1/27/20, at 2:34 p.m. R23 was interviewed in her room. R23 was observed to have a large dark purple discoloration on right upper arm. R23 stated it was bruised. R23 also stated she had bruises on her leg. "It happens when they put me on the commode and back in bed. They don't mean for it to happen but it does. My skin is so tender. It's been that way for years." R23 said she used to take blood thinners but added the blood thinners had been discontinued for a while. A review of R23's active orders showed no anticoagulant medications. R23 also pointed out "skin tears" on her left lower leg and right forearm that were covered with gauze bandages. R23 stated she believed the skin tears were from transfers as well. R23 stated "I am afraid to get out of bed anymore because of the skin tears and bruises that follow".

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F 684	Continued From page 27 On 1/28/20, at 9:57 a.m. dressing changes were observed. Licensed practical nurse (LPN)-B described the wound on the left lower leg as triangle shaped, and had improved. Wound contained small amount of tan slough. Good tissue on the edges. Small amount yellow serous drainage on old dressing. Small amount brown eschar. R23 stated there was no pain to the wound and it had improved. R23 stated she thought it happened when her legs were picked up and put back in bed, maybe by nursing assistant finger nails that might have pinched her skin. R23 denied pain with the dressing changes. LPN-B noted bruise on the right lower leg as well as a bruise on the right upper arm. LPN-B stated the bruise was not there on Sunday (two days ago). The skin tears and bruises were not measured during this dressing change. LPN-B stated if we find a bruise or skin tear the process would be to notify the director of nursing, let family know, and do an incident report on computer. On 1/28/20, at 3:15 p.m. nursing assistant (NA)-A and nursing assistant (NA)-D were interviewed. They stated R23 calls when needed and doesn't refuse cares. Instead, R23 requests her cares and tells us what she needs. NA-A and NA-D acknowledged R23 had fragile skin. They said the process is to report any new bruises or skin tears to the nurse. When interviewed on 1/29/20 at 9:08 a.m., licensed practical nurse (LPN)-A stated she did not know why the skin assessments, incident reports or interventions were not being done nor if R23 had been refusing skin assessments "it	F 684		

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hasn't been reported to me." LPN-A stated R23's skin is so fragile.

On 1/29/20, at 10:36 a.m. skin assessment was observed with registered nurse (RN)-A. RN-A completed measurements in inches instead of centimeters. RN-A removed the dressing and measured the left lower leg skin tear as 3 in. (inch) in length by 3/8 in. wide. The wound was described as pink scar tissue surrounding the wound and scabbed over. The wound was half moon shaped. The bruise on the right lower leg was measured by RN-A to be 3 1/4 in. wide by 5 1/2 in. long, purple. RN-A stated it doesn't look fresh. The bruise on R23's right upper arm was measured in three separate areas. Closest to the elbow was 1 1/2 in. long by 1 in. wide. The inner arm bruise was measured at 3 in. wide by 5 1/2 in. long. These bruises were purple with brown fading edges. There was a dark purple area within measured at 1 1/4 in. by 3/4 in. Next, the dressing was moistened and removed from the right lower arm slowly. R23 winced and reported having pain with that dressing change. R23 had pain medication in the morning already and did not want more because she did not want to be drowsy. The wound was measured at 1 1/2 in. long by 7/8 in. wide. The wound was described as having small amount of bleeding, granulated tissue, small amount of slough on the edge and half moon shaped. RN-A also noted bruises on the left upper arm. The bruises were described as multiple small purple bruises the largest one measured 1 in. x 3/4 in. RN-A stated R23 had very delicate skin and staff are to be gentle with cares. RN-A stated new bruises or skin tears need to have an incident report completed. R23 reporting being unaware of

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when the skin concerns happened as she she couldn't see the areas. R23 added what she could see, seemed to be healing.

On 1/29/20 at 11:21 a.m. the interim director of nursing (DON) was interviewed. DON stated skin assessments are expected to be done weekly. DON reported doing monthly audits on skin assessments. If the assessments were not completed, DON entered orders in to complete skin assessments within two days. DON stated the expectation for bruises or skin tears would be the nursing assistant should have notified the nurse. The nurse should make incident note and investigate the cause of the skin concern. The nurse should have notified a nurse supervisor or on call nurse. DON confirmed the only skin incident on file was the one from 1/1/20 regarding the right lower arm. There were no incident reports for the skin tear on the left lower leg, the bruise on the right lower leg, the bruise on the right upper arm, nor the bruises on the left upper arm.

Facility policy titled Skin Assessment and Wound Management dated 7/2018 indicated when a significant alteration in skin integrity is noted (i.e.. large or multiple bruising, large skin tear) the following actions will be taken: notify MD/treatment ordered, Initiate weekly non pressure wound or skin alteration evaluation, notify nurse manager, update care plan. Update resident care lists. With ongoing skin problems the skin concerns were to be reviewed with IDT at least monthly. Document refusal of treatment in medical record.

Accidents and incidents policy reviewed dated

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F 684	Continued From page 30 July 2017: Nurse supervisor, charge nurse and or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. Include on report of incident accident form: Date and time took place, nature of injury, circumstances, where, names of witnesses, injured persons account, time doctor was notified and response time, date time family notified. Condition of injured person, disposition, corrective action, follow up any pertinent info. Report of incident/accident form within 24 hours of incident. Incident accidents reports will be reviewed by safety committee for trends.	F 684		
F 689 SS=G	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 ensure 2 of 3 residents (R18, R48) were comprehensively assessed, received adequate supervision and received assistance to prevent accidents. R18 sustained harm when she fell and sustained a head injury requiring 10 staples to her head. R48 also experienced harm, when he experienced a fall resulting in a compression fracture to the lower back. The findings include:	F 689	Resident #18 is provided staff assistance with ADL's, including transfers. The Care Plan was revised to reflect current needs when the discrepancy was identified. NA-F was given a counseling and education given on providing assistance when requested on 8-7-2019. Resident #48 is provided assistance per therapy assessment for transfers and ambulation. The Care Plan was revised to reflect current needs for transfers and ambulation when the discrepancy was	3/20/20

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F 689	Continued From page 31 R18's annual Minimum Data Set (MDS) dated 3/29/19, indicated R18 had intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. The MDS also indicated R18 required assistance with activities of daily living (ADLs) including: extensive assist with bed mobility, toileting and transfers, and independence with walking. Further the MDS identified R18 was occasionally incontinent of urine, and was continent of bowel. R18's diagnoses were identified to include dementia. R18's corresponding Care Area Assessment (CAA) indicated R18 needed assistance with ADLs. The CAA indicated R18 had decreased mobility and weakness, and had been in therapy and was at maximum potential. R18 was a long term resident. The CAA included a plan to continue to assist with ADLs and monitor for decline. Additionally, R18 was noted to be at risk for falls related to muscle weakness, type 2 diabetes and history of falls. Interventions were identified to include: call light within reach and clear unobstructed path. R18 was noted to be independent with transfers in her room, with staff assist per her request for cares. R18's resident care card dated 8/7/19, indicated R18 was A1 (assist of 1) with ADL's and transfers. A facility progress note documented 8/7/19 at 2:39 p.m., indicated a nursing assistant reported R18 was on the floor at 12:40 p.m. and was bleeding from the back of the head. The note included: "Large laceration to the back of the head with little blood flow. Large hematoma	F 689	identified. A Fall Risk Assessment was completed on 3-10-2020. The Policies for Using the Care Plan and Supporting Activities of Daily Living were reviewed and remain current. All residents admitting or readmitting from the hospital will have their hospital discharge notes reviewed by the admitting nurse to assure any assistance with transfers/ambulation is identified and care planned. All nursing staff were re-educated on these policies on 3-20-20. All residents requiring assistance with transfers/ambulation Care Plans have been reviewed to assure they accurately reflect the resident needs. Recurrence will be prevented by audits of 5 residents requiring or requesting assistance with transfers or ambulation will be conducted weekly x4 then monthly x2 to assure assistance is provided. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. This will be monitored by the Director of Nursing and Nurse Managers.	

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formed directly under laceration. Resident was sent to the ER (emergency room) for evaluation." The note indicated R18 had stated, "I was trying to go to the bathroom and no one would help me."

A facility form titled Correction, Direction or Re-Education dated 8/7/19, indicated the situation was addressed by immediate conversation, education regarding assisting residents per request. Although care planned 'independent' resident may feel week, unsteady. Must assist resident, find out why/reason and report to nurse. Nursing assistant (NA)-F and registered nurse (RN)-B had signed the form.

The facility form titled Employee Statement of Reported Incident, indicated an incident had occurred on 8/7/19. The form indicated prior to the fall, R18 had asked NA-F for help to go to the bathroom. NA-F had reportedly told R18 "no" because R18 was independent in her room. NA-F had informed NA-E who had told NA-F she should have helped R18 when asked. The documentation indicated NA-E and NA-F had responded to a noise they heard from R18's room, and had observed R18 to have fallen. NA-E then got the nurse to assess R18 after the fall. The form was signed by NA-E.

A facility progress note dated 8/7/19, at 9:07 p.m. indicated R18 had returned from the hospital by ambulance with orders for an antibiotic to treat a UTI (urinary tract infection). The note further indicated R18 required assistance to the bathroom when needed, and indicated R18's staples should be removed in 10 days.

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F 689	Continued From page 33 Review of the facility treatment administration record for R18 verified an order to remove the staples. A facility progress note dated 8/15/19, indicated 10 staples were removed from occipital region of R18's head with no issues or problem. R18's occupational therapy discharge summary dated 8/9/19 - 8/19/19, indicated R18 had been upset and irritated when the caregiver did not respond to her call light promptly, and indicated R18 felt that had been the cause of her soiling her depends. R18 was able to mobilize to the bathroom with two wheeled walker with contact guard assist (cga) and transfer with cga, clothes management to push pants and depends over her hips and to complete peri care. To change the depends she required maximum assist and minimum assist to pull up the depends and pants over her hips. R18's care plan dated 10/4/19, indicated the resident had an ADL self care performance deficit related to: age related debility, muscle weakness, abnormal gait/mobility and included the following interventions: Independent with FWW (four wheeled walker) to/from bathroom. May ask for assistance if needed. Date initiated 4/4/18. R18 was interviewed on 1/27/20, at 3:01 p.m. R18 stated she remembered having fallen, but was not sure when. R18 recalled going to the hospital after the fall, and stated could no longer walk alone. R18 then stated she couldn't remember anything else about the fall and said she was tired of answering questions.	F 689		

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On 1/27/20, at 5:33 p.m. family member (FM)-E was interviewed via phone. FM-E recalled the fall R18 had in August 2019, and when the facility had called to tell him it had happened. FM-E recalled being told R18 was sent to the ER and returned. FM-E stated, "Every time [R18] falls it takes a little more out of her."

When interviewed on 1/28/20 at 9:50 a.m., trained medication assistant (TMA)-C stated the care data sheets are where the nursing assistants look to find what care residents require. TMA-C stated even if a resident was independent, if the resident asked for help staff were expected to help. A short time later, TMA-C was observed to answer R18's call light to help R18 transfer from the recliner and walk to the bathroom.

On 1/28/20 at 1:18 p.m., nursing assistant (NA)-F was interviewed by phone. NA-F recalled working with R18 on 8/7/19, the day of R18's fall. NA-F stated "before the incident [R18] did ask for help sometimes, we were always told that she was independent, that she should try doing it herself. I can't remember who told me that. At the time she was labeled as independent, but after she came back from the ER she was one assist." NA-F stated R18 never refused cares. NA-F stated there was a binder the nursing assistants could look at to see what a resident's cares included. NA-F stated after the fall on 8/7/19, "I just got talked to, they said when they (residents) ask for help you just do it." NA-F stated, "Prior to that I was under the impression that we encourage them to do it themselves if they asked for help."

On 1/28/20 at 3:06 p.m., NA-A was observed to

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answer R18's bathroom call light. NA-A assisted R18 from the bathroom to the recliner. At that time, NA-A was interviewed and stated, "If any resident asks for help, the expectation would be to help the resident. The nursing assistants look at the care data sheets in the binder by the printer room if they don't know a resident's cares. They (NA's) also talk to the nurse to find out if there are any changes to the resident's plan of care." NA-A also stated R18 does not refuse cares.

During interview on 1/29/20, at 8:59 a.m. licensed practical nurse (LPN)-A stated she had worked the day of R18's fall 8/7/19, but was not involved with the incident. LPN-A stated before that fall R18 sporadically asked for help. "Sometimes she'd ask for help and staff would help her. Now [R18] relies on others to help her all the time." LPN-A stated the expectation was for staff to help people that need it, when they ask.

At 1/29/20 at 10:42 a.m., an anonymous staff stated R18 was not fully independent before her fall on 8/7/19, but had been considered to require assist of one. The anonymous staff stated, "Even if someone was considered independent, it is our job to help the residents when they ask." The anonymous staff verified R18 does not refuse cares.

During interview 1/29/20 at 11:30 a.m., the interim director of nursing (DON) stated at the time of R18's fall on 8/7/19, R18 was independent with assist of one as needed. The DON stated, "Even when a resident who is considered to be independent asks for help, the

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resident should be helped. The nurse should be notified of any change to a resident's condition." The DON further verified R18 had asked staff for help even prior to her fall.

The facility's 3/2018 policy Supporting Activities of Daily Living, indicated residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADL's.

The facility's undated policy Using the Care Plan, indicated nursing assistants were responsible for reporting to the nurse supervisor any change in a resident's condition, or any care plan goals and objectives that had not been met, or expected outcomes that have not been achieved. Documentation must be consistent with the resident's care plan.
R48's admission MDS dated 10/25/19, identified R48 had impaired cognition, and had diagnoses which included: cerebral infarction, adjustment disorder with mixed anxiety and depressed mood, attention and concentration deficit following cerebral infarction, hemiplegia, and hemiparesis. The MDS further indicated R48 required total assistance for eating, extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene.

Review of R48's clinical record revealed there was no Fall Risk Assessment found or provided by the facility.

Review of R48's current care plan last revised 10/28/19, identified R48 as a high risk for falls related to impulsiveness due to cerebral vascular accident, forgetfulness, confusion, hemiplegia,

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and cognitive deficit: The goal indicated R48 would be safe and free from injuries due to falls. Interventions included: Ensure foot pedals are on wheelchair when resident is using. Keep phone within reach when resident in his room. Keep resident in public areas, as much as possible. Keep walker within reach. Neon tape placed on call light cord to alert resident to use call light for assistance. Offer to help resident with morning cares and getting up for the day before 7:00 a.m. per resident preference. Resident to eat meals in dining room for better observation. In addition, a sign was placed around handle of bathroom door reminding resident to use call light for help going into the bathroom. Also, signs were placed in room to remind resident to use his call light for assistance, placed on back of wheelchair to remind resident to use call light for help before transferring alone, and placed on head board reminding resident to use call light for assistance with getting into bed. Will keep urinal within reach. Low bed. Keep bed remote away from resident. Resident to wear gripper socks at night. No wheelchair (W/C) pedals for safety.

Review of a facility Incident Review and Analysis form dated 1/22/20, indicated on 1/11/20, at 8:37 p.m. R48 was attempting to use the restroom independently and fell to the floor. The form indicated R48 was complaining of lower abdominal pain and facility staff had called 911, and sent the resident to the Emergency Room for evaluation. R48 was subsequently diagnosed with a L1 compression fracture to the spine.

On 1/28/20, at 3:41 p.m. R48 was observed seated in his wheelchair at the end of the hallway. The physical therapy director was

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observed to walk away from R48 holding onto the wheelchair legs. The physical therapy director stated the wheelchair legs should be on R48's wheelchair when R48 self-propelled the chair because R48 he did not have the ability to keep his left leg up independently when he pushed the wheelchair. When the physical therapy director walked back to R48, the resident grabbed the walker and attempted to transfer himself. R48 stood up and his legs began to shake. The physical therapy director ran toward the resident to assist him and told R48 he needed to remember that he needed assistance to transfer. R48 responded back, yes he knew that. R48 then walked down the hallway holding onto the walker while wearing a transfer belt which the physical therapy director held onto.

Review of a 1/28/20, facility Visual/Bedside Kardex Report, used by NA's for care direction, directed staff that R48 required an assist of two caregivers and a Sara steady (mechanical lift) for all transfers. The Visual/Bedside Kardex also indicated the resident required an assist of two staff, and the use of a transfer belt, for ambulation with a wheelchair following.

On 1/29/20, at 7:29 a.m. NA-D entered R48's room to assist the resident with morning cares. R48 was observed to be laying in bed with no covers on. R48's bed was in a low position and the bed remote was attached to R48's left bed rail. The call light that had a neon piece of tape attached to the call button and attached to the left side rail. R48 laid on his side and played with the phone base on his night stand. NA-D raised the bed, undid R48's tabbed brief, and pulled R48 up by his arm to sit him up in bed. At 7:50 a.m., R48

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F 689	Continued From page 39 was given a walker and NA-D had resident stand. R48 removed a soiled brief from the resident. During the care, R48 held onto the walker while NA-D cleansed the resident's groin and buttock with perineal wipes, and applied a new tabbed brief. NA-D then pulled R48's pants up to the resident's waist and tightened the drawstring. R48 stood next to the bed and held onto the walker. NA-D then brought the wheelchair to the resident and NA-D went on the other side of the bed to obtain a trash bag from a garbage can while R48 stood alone and held onto the walker. R48 then turned herself and held on to the walker and sat himself in the wheelchair. No foot rests were applied to the wheelchair, and no transfer belt was present or used on R48. During interview on 1/28/20 at 2:20 p.m., the director of nursing (DON) confirmed a Fall Risk Assessment was not completed for R48 at admission or any time thereafter. The DON also stated she was not aware R48 had a compression fracture of the low back, and didn't know whether any new orders had been provided when R48 returned from the hospital. When the DON informed the resident had returned with a new prescription for Oxycodone and therapy recommendations, the DON looked through the hospital paperwork and found that R48 had an abdominal and pelvis CT without contrast, that had identified a L1 compression fracture. The DON stated she had not been made aware of this. When questioned about R48's care plan and interventions, including use of the foot pedals because the care plan indicated R48 should have the foot pedals on, and also indicated R48 should have the foot pedals off, the DON stated she thought one of the interventions should have	F 689		

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been removed from R48's care plan. When questioned whether R48's bed remote was supposed to have been removed from the resident's reach per the resident's care plan, the DON verified the remote should have been removed. The DON was then informed R48's bed remote had been placed on R48's left bed rail.

During interview on 1/28/20, at 2:40 p.m. TMA-C stated she regularly worked with R48. TMA-C stated R48 required assistance with all ADL's including bathing, toileting, and dressing. TMA-C stated R48 was an assist of 1 with the use of a transfer belt and a walker. When asked what fall interventions were in place for the resident, TMA-C could not answer but stated it was on the care sheet in a book for the caregivers to review. TMA-C went to the book to review resident's care sheet and read aloud that R48 was an assist of 2 with the use of a Sara steady. TMA-C stated she was not aware R48 was an assist of 2 with a Sara steady. TMA-C stated she had just come back from maternity leave. When asked how often she reviewed the care sheets, TMA-C stated "when there is a change". TMA-C was asked if she had reviewed the care sheets when she returned from maternity leave and she verified she had not. When questioned how she would know when the care sheets had been updated, TMA-C stated it would be written on the board or passed along in report. TMA-C then showed the writer the board that listed residents who were fall risks. R48 was on the board and next to his name was written- low bed, and to keep bed control from resident.

During interview on 1/28/20, at 3:47 p.m. the

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F 689	Continued From page 41 physical therapy director stated she believed R48 was an assist of 1 with the use of a transfer belt and a walker for transfers. The physical therapy director stated the care plan indicated R48 was an assist of 2 with a transfer belt, and when weak to use a Sara steady. The physical therapy director stated she would need to review her recommendations to see if there was a discrepancy to the care plan, and stated R48 is frequently reminded not to transfer himself, but stated he doesn't always remember, or chooses to ignore the recommendation. The physical therapy director stated R48 definitely needed assistance with transfers and shouldn't transfer himself. During interview on 1/29/20, at 8:00 a.m. RN-A stated he was unaware of how caregivers ensured they follow the care plan. RN-A stated when a resident was admitted, a care plan was developed within 24-48 hours and the DON was responsible to educate the caregivers on the care plan. RN-A also stated if staff did not follow the care plan, he would notify the DON. When asked if a registered nurse would provide any re-educating, RN-A stated if it was something minor he would re-educate but anything else he would notify the DON and she would have to re-educate. During interview on 1/29/20, at 10:49 a.m. R48's spouse stated nursing staff, as well as physical and occupational therapists, had spoken with the resident about the risks involved with self-transfers. R48's spouse also stated because of the stroke, R48 sometimes forgot he had issues with his left side, and doesn't ask for help. R48's spouse stated the nursing staff speak to	F 689		

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F 689	Continued From page 42 the R48 quite often about the risks of not asking for help. During interview on 1/29/20, at 11:22 a.m. the DON stated the staff try to give the resident as much independence as possible except for transfers. The DON stated there have been multiple conversations with the resident and spouse about the risks of not using a call light, or asking for assistance. The DON stated when she was made aware staff weren't following the care plan, a team meeting would be called to review the care plan. The DON verified there was no interdisciplinary team (IDT) meeting, but the departments of therapy, social work, nurse coordinator, DON, and nurse managers met daily and reviewed incidents. There was no documentation done for the meetings. The DON said when changes were required to a resident's care plan, the DON and nurse manager would be responsible to make the changes and educate staff. The facility policy Fall Prevention and Management (revision date 6/2019) identified nursing staff will complete a fall risk evaluation to identify and document resident's risk factors for falls upon admission, annually, with a significant change in condition and as needed. Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		3/20/20

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F 698	Continued From page 43 require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, the facility failed to assure ongoing assessment of condition and monitoring for complications before and after dialysis for 1 of 1 resident (R49) reviewed for dialysis care. R49 was admitted to the facility 1/11/20, and the admission Minimum Data Set (MDS) dated 1/17/20, indicated R49 had slight cognitive impairment and diagnoses that included end-stage renal disease. On 1/28/20, at 2:40 p.m., NA-A was interviewed and indicated R49 got up early and left the facility. NA-A stated she did not know why R49 left the facility, and was unaware that R49 was on dialysis. On 1/28/20, at 4:06 p.m. registered nurse (RN)-A was interviewed and stated R49 has dialysis 3 times per week. RN-A further stated he was unsure of monitoring requirements for this resident, but stated in general, for a resident on dialysis, the procedure would be to not assess blood pressures on the same arm that has a dialysis port or fistula and monitor for bleeding, and communication information is brought back with the resident and the RN puts it into the chart. On 1/29/20, at 10:09 a.m., licensed practical nurse (LPN)-A was interviewed and stated assessment and dialysis care was normally	F 698	Resident #49 made the informed decision to discontinue dialysis on 1-29-20 and passed away on 2-7-20. The Hemodialysis Policy was reviewed and remains current. There are no other residents currently on dialysis. All licensed nurses were re-educated on the Hemodialysis Policy. Recurrence will be prevented with all residents receiving dialysis and be audited weekly x4 then monthly x2 to assure their orders and care plan are reflective of the care, monitoring and assessment per policy. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. This will be monitored by the Director of Nursing, Nurse Managers and MDS Coordinator	

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F 698	Continued From page 44 present in the resident's care plan, and that it should be included in the 48 hour care plan for newly admitted residents. LPN-A verified there was no current order for dialysis care and no care plan interventions addressing dialysis assessment or care. On 1/29/20, at 11:39 a.m., the assistant director of nursing (ADON) was interviewed and stated it would be her expectation the dialysis care information would be entered into orders and care plan by this date for R49. The facility Hemodialysis policy dated 11/22/19 was reviewed and indicated residents who require dialysis receive services consistent with professional standards of practice, the comprehensive person-centered care plan, and residents goals and preferences. The policy further states staff will provide ongoing assessment of the residents condition and the resident will be monitored for complications before and after dialysis treatment.	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		3/20/20

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F 732	Continued From page 45 vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately reflect hours nursing staff actual worked on the daily posting. This had the potential to affect all 50 residents who resided in the facility and their visitors. Findings include: Facility Posting of Daily Hours dated 1/28/20, was observed in plastic binder at West side nurse station on 1/28/20, at 8:30 a.m. Random	F 732	Nursing hours will be posted and changes made to census or staffing each shift as indicated. The posting of Nursing Hours Policy was reviewed and remains current. The licensed nurses and staffing coordinator will be re-educated on the process for the Form. Recurrence will be prevented by audits of the Daily Nursing Hours form and completed weekly x4 then monthly x2 to assure the changes indicated are completed on each shift. The results of	

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F 732	Continued From page 46 observations of posting were observed throughout the day with no updates of hours nursing staff actual worked and/or updates with resident census changes. Licensed practical nurse (LPN)-C stated on 1/28/20, at 10:20 a.m. when nursing staff called in sick the facility would tried to replace the ill staff but could not always replace. LPN-D stated on 1/28/20, at 10:29 a.m. the director of nursing would fill in on the floor a lot as a nurse and also as a nursing assistant (NA). Staffing coordinator (SC) stated on 1/28/20, at 10:31 a.m. that she posted the Daily Posting of Hours Monday through Friday around 8:30 a.m. each day, however, the posting indicated day shift started at 6 a.m. SC stated she did not have an explanation why the posting was not placed at the beginning of the shift. SC stated when she left on Fridays she placed a daily posting in the plastic binder for Saturday and Sunday with the expectation nursing staff would remove and replace the posting each day of the weekend. SC stated when she came in on Mondays, the Friday sheet was usually still posted. SC stated nursing struggled to get this done during the weekend. SC verified the 1/1/20-1/28/20, daily postings had not been updated with any resident census changes and/or nursing staffing changes throughout each day. SC stated corporate consultant nurse had told told her to complete the posting and to post it daily, and had not told her to have it updated and stated she was unaware of the regulatory requirements regarding this. SC stated residents were admitted to and discharged from the transition care unit 1-2 times a week, up	F 732	the audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. This will be monitored by the Director of Nursing and Nurse Managers.	

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F 732	Continued From page 47 to 4-5 times a week. SC stated sometimes she would replace or fill in nursing staff with other nursing disciplines, and interchange trained medications assistants, NAs, LPNs and registered nurses (RNs) with each other. SC stated sometimes nursing staff worked actual less hours than had been scheduled and projected on the daily hours postings. SC confirmed the 1/1/20, -1/28/20, Daily Postings of Hours did not accurately reflect the actual nursing hours worked and/or resident census each shift. SC stated the facility had not kept the previous 18 months of daily postings as required as she had just been asked to start posting the nursing hours and resident census in October and had not been doing so since she started her position last August. SC stated no one else at the facility had been completing the daily hours postings. SC stated the daily postings were not an accurate reflection of the total nursing hours actual worked and/or resident census as she had not been updating the daily hours and/or census once posted. Review of nursing schedules dated 1/1/20-1/28/20, indicated changes in nursing disciplines and/or actual hours worked. Review of Daily Posting of Hours dated 1/1/20-1/28/20, did not indicate any changes/updates in nursing disciplines and/or actual hours worked and/or updates with changes in resident census. A facility policy was requested, and not made available.	F 732		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756		3/20/20

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F 756	Continued From page 48 §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced	F 756		

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F 756	Continued From page 49 by: Based on interview and document review, the facility failed to act upon consultant pharmacist recommendations for 1 of 5 residents (R5) who were reviewed for unnecessary medications. Findings include: R5's Care Area Assessment (CAA) dated 1/31/19, indicated R5 had diagnoses of dementia with behavioral disturbances and major depressive disorder. Additionally, R5 had no living family and a guardian. The Consultant Pharmacist's (CP)-A Medication Regimen Review (MRR) dated 8/14/19, noted R5 continued on citalopram (antidepressant medication) and risperidone (antipsychotic medication). Please ensure informed consent is completed. The MRR contained initials and "done" however no consent was on file during that timeframe. There was no corresponding progress note that discussed if consent was obtained. There was no MRR on file for the month of September 2019. The next MRR dated 10/9/19, indicated R5 continued on citalopram and risperidone. Please ensure informed consent is completed. The MRR contained initials and across from the consent statement was written "sent." R5's medical record contained a document titled Informed Consent for Required Medications for risperidone and citalopram. The document was dated 10/14/19. On the line for signature of	F 756	Resident #5 passed away under Hospice Care on 1-29-20. The Pharmacy Recommendation Policy was reviewed and remains current. All residents on psychotropic medications were reviewed to assure informed consents were present. The Nurse Managers were re-educated on the process for Pharmacy recommendations. Recurrence will be prevented by audits of 5 residents weekly x4 then monthly x2 will to assure Pharmacy recommendations are followed up on timely including the need for informed consents. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. This will be monitored by the Director of Nursing and Nurse Managers.	

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resident, legal guardian, conservator, attorney in fact, responsible party was written "verbal ok nephew." The document lacked a name of the nephew or a signature. Furthermore, R5 had a legal guardian appointed at that time. The legal guardian's signature was not present on the consent form. There were no corresponding progress notes which discussed how consent was obtained.

R5's care plan dated 10/17/19 indicated R5 has a potential for psychotropic drug adverse drug reactions related to daily use of psychotropic medication. Received celexa (citalopram) and risperidone for diagnosis of delirium and dementia.

R5's quarterly Minimum Data Set (MDS) dated 11/1/19, identified severely impaired cognition based on a Brief Inventory of Mental Status (BIMS) score of 00. R5 had behaviors which included physical symptoms directed toward others. Further, R5 had taken antipsychotic and antidepressant.

R5's physician progress note dated 12/5/19, indicated R5 had been on hospice and continued to benefit from citalopram and risperidone. No gradual dose reduction was needed at the time if she is was the end of her life. A decrease in medications may compromise quality of life. R5 had been monitored for worsening of any abnormal involuntary movements and none have been noted.

On 1/27/19, at 5:33 p.m. during phone interview, guardian (G)-A stated she had been R5's guardian for almost a year. Further, R5 did not

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have family members that preceded G-A as legal guardians or responsible parties.

When interviewed on 1/29/20, at 9:16 a.m. licensed practical nurse clinical coordinator (LPN)-A stated the process with psychotropic consents was an update to the family right away to get verbal consent, then as soon as we see them we get it signed.

When interviewed on 1/29/20, at 11:30 a.m., the interim director of nursing (DON) stated the process when a resident started on a psychotropic medication was: the facility would have contacted whomever POA [Power of Attorney] was with medication orders to obtain consent.

When interviewed via phone on 01/29/20, at 2:43 p.m. CP-A stated I would expect the nurses to have followed up on initial recommendation reports within a month. CP-A was not sure if consent form without proper responsible party name would be acceptable.

Psychotropic policy was requested and not received.

The facility policy Change in Resident Condition dated 6/2019 indicated the facility shall notify the resident/representative of changes in the resident's condition or status. The licensed nurse will record in the resident's medical record information relative to changes in the resident's medical condition or status.

The facility policy Consultant Pharmacist Reports dated 1/2018, indicated the consultant

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F 756	Continued From page 52 pharmacist identified irregularities through a variety of sources including the resident's clinical record, pharmacy records and other applicable documents. Recommendations are to be acted upon and documented by the facility staff and/or the prescriber.	F 756		

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Pleasant Manor Inc.) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: fm.hc.Inspections@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/16/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2020**

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K 000	Continued From page 1	K 000		

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Pleasant Manor Nursing Home is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1978, addition was constructed to the Northwest Wing that was determined to be of Type II(111) construction. In 1996, another addition was added to the Southeast Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 65 beds and had a census of 50 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored	K 923		1/29/20

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K 923	Continued From page 3 in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper organization of the med gas (O2) storage room in accordance with the Life Safety Code NFPA 101 - 2012 edition (11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)) This deficient practice could affect 50 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 01/28/2020, observations and staff interview revealed the following: During walk-through of the facility observed that the Oxygen Storage Room had mixed storage of empty and full cylinders. Proper separation of cylinders was not being maintained This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	The gas equipment - cylinder and container storage room will separate full and empty cylinders and empty cylinders will be marked as such to avoid confusion. This deficiency was corrected on 1-29-20 and will be monitored by the Maintenance Director to ensure compliance.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment.	K 926		4/3/20

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K 926	Continued From page 4 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide confirmation that proper med gas (O2) training is occuring in accordance with the Life Safety Code NFPA 101 - 2012 edition (11.5.2.1 (NFPA 99)) This deficient practice could affect 50 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 01/28/2020, observation and documentation reviewed revealed the following: During documentation review - no information was provided to confirm the facility had an employee med-gas training program This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 926	The facility trained all staff concerned with the risks associated with the application, maintenance and handling of medical gases and cylinders on April 4 and 5, 2019. The documentation of this was not located at the time of the survey. The training of staff concerned with the risks associated with medical gases and cylinders will again be completed by April 3, 2020. This will be monitored by the Administrator and Maintenance Director.	