DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 20, 2023

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

Re: Reinspection Results
Event ID: 7HG712

Dear Administrator:

On May 16, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 23, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 20, 2023

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

RE: CCN: 245272
Cycle Start Date: March 23, 2023

Dear Administrator:

On May 30, 2023, we notified you a remedy was imposed. On May 16, 2023, June 22, 2023 and June 28, 2023 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 16, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 23, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 12, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 23, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 16, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 12, 2023

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

RE: CCN: 245272
Cycle Start Date: March 23, 2023

Dear Administrator:

On March 23, 2023, a survey was completed at your facility by the Minnesota Departments 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 23, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 23, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 12, 2023

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

Re: State Nursing Home Licensing Orders
Event ID: 7HG711

Dear Administrator:

The above facility was surveyed on March 20, 2023 through March 23, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 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
	245272	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

(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 From 3/20/23 through 3/23/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not in compliance. 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 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		5/12/23

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

Electronically Signed | 04/20/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 3 Based on interview and document review, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 3/21/23, between 9:30 a.m. and 1:00 p.m., it was revealed by a review of available documentation that the facility could not provide documentation showing the facility's Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the director of environmental services verified these deficient findings at the time of discovery.	E 041	E Tag (K918) Generator Load Bank testing will be scheduled and completed before date certain. The preventative maintenance tracking system was updated to ensure Load Bank Testing is scheduled by regulation moving forward and will be monitored by the Quality Assurance Performance Improvement (QAPI) Committee. The measures that will be taken to ensure deficiency does not reoccur is a facility review of the Emergency Generator Policy. The person responsible for compliance is the director of environmental services. Date Certain: 5/12/2023	
F 000	INITIAL COMMENTS On 3/20/23 through 3/23/23, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies issued. H52727775C (MN89680), H52727674C (MN88300), H52727673C (MN88949), H52729540C (MN91193).	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 4 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to safely secure medications that were left at the bedside in reach for 3 of 3 residents (R29, R20, R53) reviewed for self-administration of medication (SAM). Findings include: R29's quarterly Minimum Data Set (MDS) dated 1/4/23, indicated R29 was cognitively intact. R29's Self Administration of Medications assessment dated 3/30/22, indicated R29 was not safely able to self-administer medications.	F 554	F554 Corrective action: R29- Voltaren gel was removed and stored in the medication cart. R 20- Nystatin powder was removed and stored in the medication cart. F53- The Triamcinolone cream was removed and stored in the medication cart, the Nystatin powder was removed and destroyed. Corrective Action as it applies to other residents: All residents currently on SAM will have their SAM assessment and care plan reviewed for appropriateness and	5/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 554	Continued From page 5 R29's orders dated 6/22/22, indicated diclofenac sodium gel 1% (medication used to relieve joint pain from arthritis), apply to bilateral knees topically four times a day for knee pain. During observation on 3/20/23 at 2:00 p.m., R29 was lying in bed, sitting up with her tray table over her bed. A tube of diclofenac sodium gel 1% was within reach on R29's tray table. When interviewed on 3/20/23 at 2:00 p.m., R29 stated the diclofenac sodium gel was often left in the room, and this time since approximately 11:30 a.m. R29 stated she would have found it on the tray table for the next scheduled administration. When interviewed on 3/20/23 at 2:10 p.m., trained medication aide (TMA)-A stated R29 had gel to apply to both knees for pain, to be administered at 8 a.m. and 12 p.m. on her shift. TMA-A acknowledged she left the diclofenac sodium gel on R29's tray table and stated all R29's medications were supposed to be secured in the medication cart and not left in the room, and further stated the facility policy was to never leave medication in the rooms. R20's quarterly MDS dated 1/9/23, indicated R20 had severe cognitive deficits, required supervision for eating, limited assistance of one staff for transfers, and extensive assistance for all other ADLs. Review of R20's facesheet documented diagnoses included dementia with behavioral disturbance, diabetes, spinal stenosis (narrowing of the spine), insomnia, spondylosis (age-related spinal fractures and/or bone spurs), anxiety, depression, right hip pain, and dysphagia	F 554	interventions. All resident rooms of residents that are not able to self-administer meds were audited to ensure medications are not being left at bedside. Self-Administration of Medication policy was reviewed and was revised. Staff responsible for administering medications and treatments were re-educated on the Self Administration of Medication policy and that medications are not permitted to be left unsecured at the resident bedside. Residents on a SAM program, medication(s) must be secured in a locked box/locked nightstand drawer) at the resident bedside. Date of Completion: 5/12/23 Recurrence will be prevented by: Random observational room audits will be completed to ensure medications are not left at bedside unsecure. 3 random observational room audits will be completed weekly for 4 weeks, then 2 random observational room audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.	

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MARTIN LUTHER CARE CENTER	1401 EAST 100TH STREET BLOOMINGTON, MN 55425

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F 554	Continued From page 6 (difficulty swallowing). R20's CAA dated 7/15/22, indicated R20 triggered for cognitive loss/dementia, communication, urinary incontinence, mood and behaviors, falls, psychotropic drug use, and pain. R20's care plan undated, indicated R20 was dependent on staff to meet her social, physical, emotional, and intellectual needs. R20 had an ADL self-care deficit related to weakness, pain, and impaired mobility with a history of self-transferring to the toilet. R20 also had a communication deficit related to a hearing impairment and would yell "help" instead of using her call light. Interventions included reminding R20 to use her call light. R20 also had pain related to diabetes, spinal stenosis, and her right hip. Interventions included encouraging R20 to call for pain medication and assistance with repositioning when in pain. R20's physician orders dated 6/3/20, indicated R20 received nystatin powder to her groin/abdomen related to a rash. R20's Self Administration of Medications (SAM) assessment dated 4/16/22, indicated R20 was not able to safely administer medications/products due to medical diagnoses, decreased fine motor skills, and an inability to recognize medications. The assessment indicated the facility interdisciplinary team reviewed the assessment and agreed with the assessment. During an observation on 3/23/23 at 8:56 a.m., a bottle of nystatin powder was on R20's nightstand.	F 554		

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F 554	Continued From page 7 During an observation and interview on 3/23/23 at 9:00 a.m., a bottle of nystatin powder was on R20's nightstand. RN-E verified the medication should not have been in R20's room if she did not have a SAM assessment that indicated R20 was safe to self-administer the medication. R53's quarterly MDS dated 1/9/23, indicated R53 had severe cognitive deficits, required supervision for eating, limited assistance for personal hygiene and extensive assistance for all other ADLs. R53's diagnoses included dementia, adjustment disorder, hallucinations, and depression. R53's care plan undated, indicated R53 had a potential for alterations in thought processes related to health decline. Interventions included monitoring for changes in R53's cognitive function, especially R53's decision-making ability, memory recall, and general awareness. R53 had a self-care deficit related to confusion. R53 had a mood problem related to depression. Interventions included offering support and encouragement as needed. R53's CAA dated 4/15/22, indicated R53 triggered for cognitive loss/dementia, visual function, communication, ADL function, and behaviors. R53's SAM dated 11/18/22, indicated R53 was not able to safely administer medications/products due to impaired cognition and inability to recognize products. The assessment also indicated R53 and R53's representative preferred to have her medications administered by the facility. The assessment also	F 554		

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F 554	Continued From page 8 indicated the facility interdisciplinary team reviewed the assessment and agreed with the assessment. R53's physician orders dated 12/19/22, indicated R53 received triamcinolone acetonide cream 0.1% (an anti-inflammatory). R53's orders lacked indication that R53 had a physician order for nystatin powder (anti-fungal) or miconazole cream (used to treat a fungal infection in the mouth). During an observation on 3/20/23 at 1:32 p.m., A tube of triamcinolone acetonide cream; expiration 10/24, was on R53's bedside table, and a bottle of nystatin powder; expiration 7/31/22, was on R53's nightstand next to her bed. During an observation on 3/21/23 at 1:51 p.m., R53 was sitting in a recliner with a bedside table in front of her. A tube of triamcinolone acetonide cream; expiration 10/24, was on R53's bedside table, and a bottle of nystatin powder; expiration 7/31/22, was on R53's nightstand next to her bed. R53 stated she did not know what the medications were used for. During an observation and interview on 3/22/23 at 11:55 a.m., RN-E stated medications were not to be left in resident rooms unless the resident had a SAM assessment completed that indicated the resident was safe to self-administer medications. RN-E was unsure if R53 had a safe SAM assessment completed and removed the medications from R53's room. During an interview on 3/23/23 at 1:23 p.m., the director of nursing (DON) stated medications should not be left in resident rooms unless the	F 554		

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F 554	Continued From page 9 resident had completed a SAM assessment and was determined to be safe to self-administer medications, especially in the memory care unit. The facility Self Administration of Medications (SAM) policy dated 6/17, indicated a SAM assessment was to be completed for any resident who requested to administer medications without the direct supervision of a nurse. Only medications permitted for self-administration were to be left at the resident's bedside and medications were not to be retained after their expiration date.	F 554		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring call light were accessible for 5 of 5 residents (R11, R20, R53, R61, R426). Findings include: R11's quarterly Minimum Data Set (MDS) dated 2/13/23, indicated R11 had moderate cognitive deficits, was independent with eating and required extensive assistance with all other activities of daily living (ADLs). R11's Care Area Assessment (CAA) dated	F 558	F558 Corrective Action: Call lights for R11, R20, R53, R 61 and R426 placed within reach of the residents. Corrective Action as it applies to other residents: The call light policy was reviewed and revised. All staff were re-educated that call lights need to be within reach of the residents. Date of Completion: 5/12/23	5/12/23

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F 558	Continued From page 10 11/16/22, indicated R11 triggered for visual function, urinary incontinence, falls, and psychotropic medication use. R11's care plan undated, indicated R11 had a self-care deficit and limited mobility weakness, a history of falls with a rib fracture, and blindness. Interventions included encouraging R11 to use the call light for assistance. R11 also had a fall related to poor balance and an unsteady gait. Interventions included keeping frequently used items within his reach and encouraging R11 to call for assistance when in pain. R11 was also on oxygen therapy related to low oxygen levels. Interventions included an agreed upon method to call for assistance, such as a call light. R11's diagnoses included heart failure, legal blindness, insomnia, and depression. During an interview and observation on 3/20/23 at 6:10 p.m., R11 was sitting in a recliner in his room. A bedside table was to his left, horizontal between him and his bed. R11's call light was draped across the opposite end of the table, out of R11's reach. During an interview on 3/20/23 at 6:27 p.m., nursing assistant (NA)-F verified R11's call light was not within R11's reach. NA-F stated it was important for all residents to have access to their call lights so they could call for help and for R11 to know where the call light was because he could not see it. R20's quarterly MDS dated 1/9/23, indicated R20 had severe cognitive deficits, required supervision for eating, limited assistance of one staff for transfers, and extensive assistance for all	F 558	Recurrence will be prevented by: Random observational audits will be conducted to ensure call lights are within reach of residents. 3 random observational audits will be completed weekly for 4 weeks, then 2 random observational audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.	

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F 558	Continued From page 11 other ADLs. R20's CAA dated 7/15/22, indicated R20 triggered for cognitive loss/dementia, communication, urinary incontinence, mood and behaviors, falls, psychotropic drug use, and pain. R20's care plan undated, indicated R20 was dependent on staff to meet her social, physical, emotional, and intellectual needs. R20 was experiencing flashbacks of a previous trauma that occurred in her life due to the progression of her dementia. Interventions included providing R20 with reassurance she was in a safe environment. R20 had an ADL self-care deficit related to weakness, pain, and impaired mobility with a history of self-transferring to the toilet. R20 also had a communication deficit related to a hearing impairment and would yell "help" instead of using her call light. Interventions included reminding R20 to use her call light. R20 was at risk for falls. Interventions included keeping R20's call light within reach and providing a prompt response to R20's requests for assistance. R20 also had pain related to diabetes, spinal stenosis, and her right hip. Interventions included encouraging R20 to call for pain medication and assistance with repositioning when in pain. R20 had urinary incontinence. Interventions included toileting R20 as requested. R20's diagnoses included dementia with behavioral disturbance, diabetes, spinal stenosis (narrowing of the spine), insomnia, spondylosis (age-related spinal fractures and/or bone spurs), anxiety, depression, right hip pain, and dysphagia (difficulty swallowing). During an observation on 3/21/23 at 6:50 a.m., R26 entered R20's room while R20 was lying in	F 558		

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F 558	Continued From page 12	F 558		

bed, facing away from the door. R26's door was open; her blinds were closed, and the lights were off. R26 walked to R20's bed causing R20 to turn and tell R26 "Don't come in here! You can't come in here!" R20 turned away from R26 but remained in R26's room. R26's call light was on the floor, under her nightstand, therefore, R20 was unable to call staff for assistance. At 6:54 a.m., the administrator entered R26's room, said hello to R20 and asked R26 if she needed assistance. The administrator then placed the call light on R26's bed and left the room.

R53's quarterly MDS dated 1/9/23, indicated R53 had severe cognitive deficits, required supervision for eating, limited assistance for personal hygiene and extensive assistance for all other ADLs.

R53's care plan undated, indicated R53 had a potential for alterations in thought processes related to health decline. Interventions included monitoring for changes in R53's cognitive function, especially R53's decision-making ability, memory recall, and general awareness. R53 had a self-care deficit related to confusion. R53 had a mood problem related to depression. Interventions included offering support and encouragement as needed. R53's diagnoses included dementia, adjustment disorder, hallucinations, and depression.

R53's CAA dated 4/15/22, indicated R53 triggered for cognitive loss/dementia, visual function, communication, ADL function, and behaviors.

During an observation and interview on 3/21/23, at 1:51 p.m. R53 sat in a recliner in her room with the call light wrapped around the grab bar of her

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F 558	Continued From page 13 bed, out of R53's reach. R53 stated the call light was "always" wrapped around the grab bar. R53 stated she wished she "had some manner of contacting someone," and had yelled for "a while" the previous day before someone came to help her. However, R53 stated yelling doesn't always work. R61's facesheet dated 3/23/23 stated diagnosis of Alzheimer's, heart failure, repeated falls, and rheumatoid arthritis. R61's care plan intervention dated 6/23/21 stated "Be sure call light is within reach and encourage to use it for assistance as needed". Observation on 3/20/23, at 1:17 p.m. R61 sat in the recliner chair in her room calling out for assistance. Call light located on top of bed and not in reach of R61. During Interview on 3/20/23 at 1:20 p.m., NA-C stated R61 call light "should have been with her in reach" and verified it was not in reach of R61. Observation on 3/22/23, at 9:40 a.m. R61 sat in the recliner chair in her room with call light attached to bed rail of resident bed. Call light was not in reach of R61. During interview on 3/22/23 at 9:40 a.m., registered nurse (RN)-D confirmed the call light was not in reach of R61 and stated call light accessibility is "for her safety". During interview on 3/22/23 at 9:45 a.m., NA-D stated she was the staff member who assisted R61 to sit in her recliner this morning and "forgot"	F 558		

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F 558	Continued From page 14 to attach the call light within reach of R61. NA-D stated "it is important she has it close for her safety". R426's admission MDS dated 3/14/23, indicated R426 had intact cognition was independent for eating, required total assistance for dressing and extensive assistance for all other ADLs. R426's diagnoses included diabetes, urinary incontinence, seizures, dementia, schizoaffective disorder, and depression. R426's CAA dated 3/14/23, indicated R426 triggered for cognitive loss/dementia, urinary incontinence, psychosocial well-being, falls, behavioral symptoms, and psychotropic drug use. R426's care plan undated, indicated R426 was on hospice. R426 also had an ADL self-care deficit and was at risk for falls related to limited mobility and weakness. Interventions included ensuring R426's call light was within reach and R426 needed a prompt response to all requests for assistance. R426 also had a potential for pain related to wounds, limited mobility, and hospice status. Interventions included responding immediately to any complaint of pain, encouraging R426 to call for assistance when she needs to be repositioned and/or wants medication due to pain. During interview and observation on 3/21/23 at 1:33 p.m., R426 was in bed and her call light was on the floor, under her bed, not within R426's reach. R426 stated her call light was on the floor out of her reach and asked for it to be placed on her bed.	F 558		

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F 558	Continued From page 15 During an interview on 3/21/23 at 1:38 p.m., licensed practical nurse (LPN)-B verified R426's call light was on the floor and out of R426's reach. LPN-B stated R426's call light should be clipped to her sheets and within her reach so R426 could call for help if she needed it. During interview on 3/22/23, at 12:51 p.m., director of nursing stated expectation was call lights "must be in reach of residents" at all times. Facility policy on accomodation for call lights was requested and not received.	F 558		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		5/12/23

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F 656	Continued From page 16 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a comprehensive assessment and person-centered care plan was completed for 1 of 1 residents (R11) who was legally blind. Findings include: R11's quarterly Minimum Data Set (MDS) dated 2/13/23, indicated R11 had moderate cognitive deficits, was independent with eating and required extensive assistance with all other activities of daily living (ADLs).	F 656	F656 Corrective Action: R11's care plan was reviewed and updated to include his individual preferences for placement of personal items, room arrangement, assistance needed with written communications and preferences for personal interactions r/t his blindness. Corrective Action as it applies to other residents: The policy for care plans was reviewed and remains current. Staff responsible for development of the care	

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F 656	Continued From page 17 R11's diagnoses included heart failure, legal blindness, insomnia, and depression. R11's Care Area Assessment (CAA) dated 11/16/22, indicated R11 triggered for visual function, urinary incontinence, falls, and psychotropic medication use. R11's care plan undated, indicated R11 preferred to be notified and invited to larger group activities. Interventions included providing R11 with a monthly activity calendar although R11 was legally blind and unable to read. R11 was at risk for pain related to a fall with a rib fracture. Non-pharmacological interventions included walking/ambulation and reading although R11 was non-ambulatory and was legally blind. R11's care plan also indicated R11 had impaired visual function related to being legally blind. Interventions included the following: -Administering eye medications as ordered -Scheduling consultations with the eye practitioner as needed -Monitoring and recording "factors affecting visual function including physiological (glaucoma, cataracts, color discrimination, light sensitivity), environmental (poor lighting, monochromatic color scheme), choice (refuses to wear glasses, use mag glass [magnifying glass], turn on lights) etc." -Monitor/report acute eye problems including R11's ability to perform ADLs, sudden visual loss, double vision, tunnel vision, blurred or hazy vision. -"Tell where you are placing their items. Be consistent." R11's care plan lacked indication of R11's	F 656	plan were re-educated that care plans must be individualized, and person centered to meet their needs identified in the comprehensive assessments. All residents care plans of those who are legally blind were reviewed to ensure they are individualized based on the assessment and resident preferences for care. Date of Completion: 5/12/23 Recurrence will be prevented by: Random care plan audits will be completed to ensure the care plan is individualized and reflects the resident preferences for care. 3 random care plan audits will be completed weekly for 4 weeks, then 2 random care plan audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.	

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F 656	Continued From page 18 individual preferences for the placement of his personal items, how R11 preferred his room to be arranged, R11's need for assistance with written communications, or R11's preferences for personal interactions as they related to his blindness. During an interview on 3/20/23 at 6:09 p.m., R11 was sitting in his room in a recliner with a padded arm brace on his right arm and wrist. R11 stated he attempted to put the brace on but because it had multiple straps and he was unable to figure it out. R11 stated there were instructions posted on his wall, however, because he was blind, they were not helpful. R11 also stated he occasionally got frustrated during meals because some staff don't tell him where his food is on his plate or assist him to cut it up. R11 stated because there was often new staff, the "messages don't get passed down." A bedside table was to R11's left, horizontal between him and his bed. A tape player was next to him, and a speaker and his cell phone were beyond it, out of R11's reach. R11's call light was also draped across the opposite end of the table, out of R11's reach. During an observation and interview on 3/22/23 at 9:07 a.m., R11 stated he wished the large oxygen tank in the corner of his room was removed or moved next to his TV. R11 stated he had not used it for five months and it was always in his way. R11 had electronic devices plugged into an outlet on the window bench behind the tank, making them difficult to access. During an interview on 3/22/23 at 11:03 nursing assistant (NA)-G stated the NAs used a resident's Kardex to know how to care for them. NA-G also stated most of the staff in the memory care unit	F 656		

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F 656	Continued From page 19 had worked there for a long time and were familiar with the residents. During an interview on 3/22/23, at 11:22 a.m., registered nurse (RN)-E stated staff would reference the resident's Kardex which was posted in their closet to know how to care for them and/or what their preferences were. During an interview on 3/22/23, at 12:22 p.m., RN-G stated the MDS coordinator was responsible for creating resident care plans and the resident Kardex was pulled from the care plan to reflect the resident's needs. During an interview on 3/23/23 at 11:07 a.m., RN-B stated she would update resident care plans to reflect their current status during the resident's quarterly assessment or as needed. A facility policy for care planning was not provided.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily	F 676		5/12/23

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F 676	Continued From page 20 living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to provide shaving assistance for 2 of 2 residents (R72, R78), and failed to provide scheduled baths for 1 of 1 resident (R87) reviewed for activities of daily living (ADL). Findings include: R72's admission Minimum Data Set (MDS) dated 3/3/23, indicated R72 had moderate cognitive impairment, required extensive assistance with most activities of daily living (ADLs), and had medical diagnosis of diabetes type II and urinary	F 676	F 676 Corrective action: R72 and R78 had facial hair removed. R87 received a shower on 3/22/23 the day after he moved rooms. Corrective action as it applies to other residents: The policies for AM, HS cares and bathing/showering were reviewed and remain current. All nursing staff were re-educated on the policies as it relates to facial hair and bathing. Date of Completion: 5/12/23	

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F 676	Continued From page 21 tract infection. R72's care plan indicated R72 had an ADL self-care deficit and required assistance from one staff member to complete personal hygiene. During observation on 3/20/23, at 3:37 p.m. R72 was noted to have long chin hairs approximately one inch long. During observation on 3/21/23, at 2:55 p.m. R72 was noted to have long chin hairs approximately one inch long. During observation and interview on 3/22/23, at 7:29 a.m. R72 still had long chin hairs after receiving a shower by facilty staff that morning. R72 stated the desire to have long chin hairs to be cut or shaved. however the facility failed to offer or assist with being shaved. During an interview on 3/22/23, at 10:27 a.m. nursing assistant (NA)-M stated we shave residents in the shower and will generally "shave the men but not the women". NA-N stated they should offer to shave all residents who have facial hair. During an interview on 3/22/23, at 12:22 p.m. registered nurse (RN)-G stated the expectation was for the nursing assistants to offer to shave facial hair when assisting with personal hygiene. R87's admission MDS, dated 2/28/23, indicated R87 was cognitively intact, needed assistance with personal hygiene and bathing from one staff member, and had medical diagnoses of weakness, acute respiratory failure, congestive	F 676	Recurrence will be prevented by: Random observational audits will be completed to ensure the facial hair and bathing is completed according to the plan of care. 3 random observational audits will be completed weekly for 4 weeks, then 2 random observational audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.	

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F 676	Continued From page 22 heart failure (a chronic condition in which the heart doesn't pump blood as well as it should producing symptoms such as shortness of breath, fatigue, swollen legs, and rapid heartbeat) and chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems). R87's care plan, indicated R87 had an ADL self-care deficit and required assistance from one staff member with showers, personal hygiene and oral care. R87's shower tasks in the electronic medical record (EMR), indicated R87 received two showers since admission, one on 2/27/23 and another on 3/13/23. During an interview on 03/21/23, at 8:31 a.m. R 87 stated staff refused to shower him Monday evening (3/20/23), his usual shower day due to his new diagnosis of pneumonia. R87 stated staff did not offer to wash him up or give him a sponge bath. R87 further stated, "I even needed to use the toilet and they refused to bring me. I had to use my urinal on my own." During observation and interview on 3/22/23, at 8:58 a.m. R87 was in the same dirty shirt covered in ffod debris as yesterday. R87 stated staff had not offered to, or washed him up, since he missed his shower on Monday. During an interview on 3/22/23, at 9:10 a.m. RN-G stated it would be expected the staff offer to give a bed bath, instead of a shower, to someone on isolation precautions for pneumonia. RN-G further stated staff did not reprot R87 missed his shower, and would expect staff to	F 676		

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F 676	Continued From page 23 reprot anytime a shower or bath is missed. A facility policy titled, "AM Cares", revised on 10/21, indicated the staff should shave women's and men's facial hair. A policy on bathing was not received.	F 676		
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, observation, and document review the facility failed to ensure staff could communicate effectively to 1 of 1 resident (R51), a non-English speaking resident, reviewed for communication. Findings include: R51's quarterly Minimum Data Set (MDS) dated 2/1/23, indicated moderate cognitive impairment, the preferred language was Vietnamese and needed/wanted an interpreter for communication. The MDS further indicated no behaviors, R51 required assistance of two staff for bed mobility and transfers, and assistance of one staff for eating, toileting and personal hygiene. R51's care plan updated 2/13/23, indicated to utilize Vietnamese interpreter as needed and at times, use interpreter to help with communication barriers but lacked indication when interpreter services were required. The care plan indicated R51 had a communication resource book to use	F 677	F677 Corrective action: Staff caring for R51 were re-educated to utilize R51's communication book or utilize interpreter services to communicate effectively. Corrective action as it applies to other residents: All non-English speaking residents were reviewed to ensure there are interventions in place to communicate effectively. The interpreter services policy was reviewed and remains current. All staff were re-educated on utilizing communication tools to effectively communicate with those residents who are non-English speaking. Date of Completion: 5/12/23 Recurrence will be prevented by: Random observational audits will be completed to ensure staff are utilizing the individualized	5/12/23

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F 677	Continued From page 24 with pictures and words in Vietnamese. When interviewed on 3/20/23, at 6:33 p.m. FM-E with FM-F on the phone, stated staff cannot communicate with R51 in her language, does not utilize a language line, and asks family to communicate with (R51), "For critical things." When observed on 3/21/23, at 09:20 a.m. the wall across from administration offices next to the front entry displayed a poster with the free language line numbers listed. The poster indicated the numbers were available 24 hours a day, seven days a week. When observed on 3/21/23, at 9:39 a.m. trained medication aide (TMA)-A fed R51 and asked R51 in English if she had pain. R51 touched her forehead and stated, "Yes." TMA-A did not utilize the communization resource book to identify pain. When interviewed on 3/22/23, at 7:54 a.m. nursing assistant (NA)-A stated when staff could not communicate with R51, staff asked the family for help or could request an interpreter but did not know how long it would take to get an interpreter on the phone. NA-A stated staff did not get R51 up in the mornings anymore because R51 did not want to get up, but did not know when R51 was last asked, did not ask himself, and did not know why there was a note on the wall which instructed staff to get R51 up in the mornings. When observed on 3/22/2, at 8:55 a.m. registered nurse (RN)-A and NA-A repositioned R1 and replaced dirty linens. A sign on the wall indicated get R51 up in her chair for breakfast daily and another sign indicated place walker near the bedside. There was a hand-written list of a few	F 677	communication tools developed for the resident. 3 random observational audits will be completed weekly for 4 weeks, then 2 random observational audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.	

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F 677	Continued From page 25 common phrases on the wall to use with R51 written in English and Vietnamese. The print was not visible from R51's bed, however, there were a few common phrases posted on the wall written in larger print. RN-A asked R51 in English if she had pain and asked R51 to rate it on a scale of zero to five. R51 indicated five the first time. RN-A asked again and R51 indicated three the second time. RN-A did not use the communication resource book with R51 to more accurately assess her pain. When interviewed on 3/22/23, at 8:55 a.m. RN-A stated R51 understood some communication with staff and staff could point to the phrases on the wall to aid in communication. RN-A stated staff utilized family to help schedule appointments, like dental, and when there were medication changes staff asked family to explain them to R51. RN-A further stated she did not know for certain if R51 understood the question about pain. and the pain assessment did not seem accurate as R51 indicated two different pain ratings, so staff used R51's facial expressions to assess pain sometimes. When interviewed on 3/22/23, at 8:55 a.m. NA-A, who also works as a TMA, stated staff had given R51's family members medication to administer when R51 would not take it and had not used the communication resource book to communiate with R51 to explain the medications to R51. When observed and interviewed on 3/22/23, at 9:02 a.m. licensed practical nurse (LPN)-A with RN-A observing, performed a pain assessment by wrapping both arms around the body in a hugging position and swaying the body side to side, then asked R51, "Pain?" R51 replied yes.	F 677		

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F 677	Continued From page 26 LPN-A stated she was not sure the resident understood the question, so LPN-A used a counting method in which LPN-A held up five fingers and pointed to each finger while counting to five in English. R51 repeated each number as LPN-A stated them. After the number five, LPN-A asked R51, "Five, is it five?" R51 stated, "Yes." LPN-A acknowledged uncertainty if R51 understood the pain assessment and stated, "Sometimes we call the family to assess the pain and sometimes interpreters come for general assessments." LPN-A further stated staff could acquire a facial grimaces chart to assess pain, but did not know how to teach R51 to use it. LPN-A stated staff could ask the family for help or request an interpreter from the social services staff. LPN-A further stated the facility had a language line and blue phones staff could use to call an interpreter however, didn't know why R51 didn't have a blue phone in her room. When interviewed on 3/22/23, at 11:46 a.m. RN-B stated pain assessments for the MDS were performed by asking R51 if she had pain and if R51 had little or no response, would wait until an interpreter could come for a scheduled assessment. RN-B stated it was not often asking R51 about her pain for the MDS assessment would provide a good assessment or pain interview and had never utilized the language line or the communication resource book for the pain assessment. When interviewed on 3/22/23, at 11:54 a.m. social worker (SW)-A stated SW staff utilized a specific list of interpreters who knew R51 well, as listed in the medical record for assessments. SW-A stated staff had a blue phone (language line phone) for residents who required an	F 677		

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F 677	Continued From page 27 interpreter for communication and the phone should have been in the room. SW-A stated her back-up plan for communication when the interpreter was not available was to utilize R51's daughter as an interpreter, but preferred a formal interpreter to ensure information was shared appropriately to R51. SW-A stated when R51 spoke, "Sometimes her yes/ no answers can be wrong, sometimes she can talk about something totally off track, and mumbles." "We have a communication book for her as well." SW-A stated the interpreters trained SW staff how to use the communication resource book with R51, SW staff had in turn given activity staff some sentences to utilize to communicate with R51, and further stated the communication resource book was located in the nightstand drawer in R51's room for all staff to utilize. SW-A stated would work with an interpreter to develop words and pictures for R51's medication list and medication administration but nursing staff had not indicated it was a problem. Additionally, SW-A stated sometimes R51 did not answer questions when asked. When observed on 3/22/23, at 11:56 a.m. the communication resource book contained pictures with names of different foods, pictures of different activities, and words and pictures to describe pain in both English and Vietnamese. When interviewed on 3/22/23, at 12:20 p.m. nurse practitioner (NP)-C stated NP communication during assessments was completed using an interpreter, but staff communication with R51 could be better. When interviewed on 3/23/23, at 10:00 a.m. R51's interpreter stated there were no staff who	F 677		

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F 677	Continued From page 28 spoke to R51 in Vietnamese, but R51 preferred to communicate in Vietnamese and responded best to simple one-sentence or yes/no questions. The interpreter further stated R51 often chose not to respond to staff when they tried to communicate with her. When interviewed on 3/22/23, at 10:00 a.m. with the interpreter, R51 stated she is hungry most of the time and would like to get out of bed in the mornings like she used to, but then changed her answer to no she would not like to get out of bed. R51 stated she had no pain at the time, but sometimes the pain was up to a rating of ten on a scale of zero to ten, in her head, knees, or legs. R51 stated staff does not use the communication resource book with her. R51 did not answer some of the questions asked through the interpreter, instead looked away. When interviewed on 3/22/23, at 10:32 a.m. RN-A stated staff could try to use the communication resource book with R51, but it was still difficult to communicate with R51 as she was not always consistent with her answers and showed signs of increased cognitive change. RN-A further explained R51 did not always choose to communicate with or answer staff when they tried to talk to her. The Interpreter Services policy revised 12/2016, indicated interpreter services are utilized to promote optimal communication with non-English speaking residents to ensure compliance with Title VI of the Civil Rights Act of 1964, the American Disabilities Act, and other federal and state laws that address how services are provided to persons with limited English proficiency.	F 677		

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F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident with limited mobility and on a walking program received appropriate assistance to maintain or improve mobility for 1 of 1 residents (R78) reviewed for mobility. Findings include: R78's admission Minimum Data Set (MDS), dated 2/28/23, indicated R78 had mild cognitive impairment, needed limited physical assistance from one staff member for most activities of daily living (ADLs) including walking, and medical diagnoses which included aspiration pneumonia due to inhalation of food or fluids, adult failure to thrive (a syndrome of weight loss, decreased	F 688	F 688 Corrective Action: F78- discharged home on 4/11/23. Corrective action as it applies to other residents: All residents on ambulation programs will have charts audited to ensure that all walking program recommendations have been added to the care plans and that care plans are followed so residents receive the required therapies The policy for ambulation and restorative nursing program were reviewed and remain current. All nursing staff were re-educated on the need to follow individualized walking programs.	5/12/23

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F 688	Continued From page 30 appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and unspecified dementia. R78's care plan indicated R78 had limited physical mobility related to weakness and was on a nursing restorative walking program. The care plan indicated R78 was independent with ambulation in her room but needed assistance from one staff member to ambulate on the unit, two times a day. R78's ambulation program documentation indicated R78 had been walked 3 times in the past nine days, once a day on 3/14/23, 3/16/23, and 3/17/23. During observation on 3/20/23, at 6:49 p.m. R78 was laying in bed, in her room alone. During observation on 3/21/23, at 2:56 p.m. R 78 was laying in bed without staff interaction. During an interview on 3/20/23, at 6:15 p.m. R78's family member (FM)-N stated R78 had finished with physical therapy and nobody was walking her anymore. FM-N stated she had asked multiple nurses to walk R78 and had received a different answer each time as to why they were not walking R78. One nurse stated R78 could ask the staff to walk with her and another nurse stated therapy would need to be consulted. FM-N further voiced concerns R78 was going to, "lose all of her gains from therapy" and was isolated to her room as she was not "allowed" to ambulate in the hallways alone.	F 688	Date of Completion: 5/12/23 Recurrence will be prevented by: Random chart audits will be completed to ensure staff are completing ambulation program per the care plan. 3 random audits will be completed weekly for 4 weeks, then 2 random audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.	

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F 688	Continued From page 31 During an interview on 3/22/23, at 10:27 a.m. nursing assistant (NA)-M and NA-N stated R78 was able to ambulate in her room on her own but not in the hallway on the unit. NA-N further stated, "we only walk her if she asks us to." NA-M stated they use the Kardex to know how to care for a resident. The information from the Kardex is pulled from the resident's care plan. During an interview on 3/22/23, at 12:22 p.m. registered nurse (RN)-G stated R78 was on a walking program and the expectation was the nursing assistants walk up and down the unit hall with R78 twice a day During an interview on 3/22/23, at 1:24 p.m. RN-F stated if a resident was consistently not participating in a walking program, or it was not being done, the resident would be re-evaluated for therapy. RN-F stated the staff document when they walk with residents on an ambulation program under the ambulation program task in the electronic medical record (EMR). When reviewing how often R78 was being ambulated, RN-F stated, "Oh, I should have caught that by now," and indicated R78 should be re-evaluated for therapy due to lack of documented ambulation with R78. During an interview on 3/23/23, at 12:44 p.m. the director of nursing (DON) stated the expectation for walking programs was to keep the nurse manager, (RN-F), informed if a resident was not participating in the program. The resident would then be reevaluated for therapy if needed. A facility policy titled Ambulation, revised on 12/17 indicated it was the policy of the facility to assist	F 688		

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F 688	Continued From page 32 residents to achieve optimum ambulation function as long as possible and the nursing assistance should use the care plan for instructions on how and how often to ambulate a resident.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess, create and implement intervention to promote the safety for 1 of 1 residents (R26) who resided in the memory care unit, had an unwitnessed fall, and continued to ambulate without assistance. Findings include: R26's quarterly Minimum Data Set (MDS) dated 1/30/23, indicated R26 was unable to complete the Brief Interview for Mental Status (BIMS). The staff assessment indicated R26 had severe cognitive deficits. R26 was independent for eating and required extensive assistance of one staff for all other activities of daily living (ADLs). R26 also required limited assistance of one person physical assist for walking. R26's facesheet indicated R26's had diagnoses	F 689	F689 Corrective Action:¿R26- A comprehensive fall assessment was completed and care plan was updated based off the results of the falls assessment. Corrective Action as it applies to other residents: All residents for high risk for falls will have their care plans reviewed for appropriate interventions. ¿Falls Risk-Post Fall policy was revised and remains current. All nursing staff will be re-trained on the falls risk-post falls policy. Date of Completion: 5/12/23 Recurrence will be prevented by: Random chart audits will be completed to ensure appropriate interventions determined by the comprehensive assessment are care	5/12/23

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F 689	Continued From page 33 including aphasia (a brain disorder affecting language and comprehension), Alzheimer's disease, dementia with behavioral disturbance, diabetes, corns and callosities (a thick, hard and painful raised bump), pain in right and left feet and toes, right and left feet hammer toes (an abnormal bend in the toes that can be painful), osteoarthritis (decreased bone density), and abnormalities of gait and mobility. R26's Care Area Assessment (CAA) dated 8/9/22, indicated R26 triggered for cognitive loss/dementia, communication, urinary incontinence, behaviors, psychotropic drug use, and falls. R26's care plan undated, indicated R26 was dependent on staff for meeting her social, physical, emotional, and intellectual needs and enjoyed walking independently, and with staff, around the unit. Interventions indicated R26 liked holding hands with staff. R26 had an ADL self-care deficit related to advanced dementia and aphasia. Interventions included a hand-hold assist of one in the ambulation program for walking R26 to and from the bathroom and meals and ambulating with R26 in the hallway 2-3 times per day if she did not go to meals. R26 may attempt to transfer independently due to poor memory and required a stand-by assist for ambulation and set-up with cues when moving between surfaces. R26 had limited physical mobility related to dementia, weakness, and a history of falls. Interventions included assistance of one staff for locomotion using a wheelchair, although R26 did not use a wheelchair. The care plan also indicated R26 had a communication deficit. R26 did not speak and was unable to make her needs known, making it difficult to know	F 689	planned. 3 random chart audits will be completed weekly for 4 weeks, then 2 random chart audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.	

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F 689	Continued From page 34	F 689		

her comprehension. R26 was also at risk for falls related to confusion, impulsivity, being unaware of her safety needs and incontinence. Interventions included anticipating her needs, frequent checks when R26 is in bed, providing a safe environment with even floors free from clutter, adequate lighting, accessible call light, low positioned bed, and transferring R26 to the couch or chair when sitting in the lounge. R26 had a potential for mood alteration related to hallucinations.

R26's Nurse Report Sheet undated, indicated R26 was on a walking program.

R26's Physical Therapy Evaluation and Plan of Treatment dated 7/14/22, indicated R26 was referred to physical therapy on 7/14/22, after a fall the previous week.

R26's Physical Therapy Discharge Summary dated 8/11/22, indicated R26 required supervision or touching assistance for all transfers, ambulation, and picking up objects.

R26's quarterly Fall Risk Assessment dated 1/27/23, indicated R26 had a score of 13 where a total score greater than 10 indicated R26 was a "HIGH RISK" for potential falls.

R26's post-fall Fall Risk Assessment dated 2/24/23, indicated R26 scored a 13 and was a "HIGH RISK" for potential falls. Although R26 had a fall on 2/19/23, the risk assessment indicated R26 had "no fall in the previous three months" and decreased muscular coordination.

R26's task documentation dated 3/8/23 to 3/21/23, indicated R26 moved independently between locations in her room and adjacent

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F 689	Continued From page 35 corridor as follows: -3/8/23, at 3:34 p.m. -3/13/23, at 2:58 p.m. -3/17/23, at 1:10 p.m. -3/18/23, at 1:59 p.m. -3/19/23, at 9:46 p.m. -3/21/23, at 1:37 p.m. During a continuous observation in the memory care unit on 3/20/23 from 6:32 p.m. to 7:00 p.m., R26 was sitting on a couch in the day room while R19 slept in a recliner in the corner. R26 dropped a magazine on the floor and made multiple, unsuccessful attempts to pick it up by scooting forward on the couch and bending forward; no staff were present. At 6:34 p.m. after rocking back and forth multiple times, R26 stood up from the couch, adjusted her sweatshirt and stepped forward on her left foot, rocking back and forth and staring at the magazine on the floor. R26 then walked across the day room to another couch. R26 was wearing long jeans that wrapped under her heals; the right pant leg had a torn hem at the bottom that dragged on the floor. R26 continually attempted to pull her pants up as she walked. At 6:36 p.m. R26 continued to shift her weight back and forth while turning in a circle. At 6:37 p.m. R26 turned around and walked to the middle of the room, then to a chair on the other side of the first couch. R26 pulled on the chair arm, moving the chair slightly and rocked back and forth on her feet while pulling up her pants. At 6:38 p.m., R26 sat back down on the first couch. No staff were present. At 6:40 p.m., R26 began rocking back and forth on the couch and at 6:41 p.m. stood up. With no staff present, at 6:42 p.m., R26 walked out of the day room, then turned around and grabbed the handle of a floor sweeper propped in the corner of the day room	F 689		

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F 689	Continued From page 36 which she was unable to lift. R26 turned back towards the couch and R19 began screaming "Help! Help! Help! I need help over here! Somebody help me! God almighty what the [explictive] is this!" R26 walked over to R19, turned around and walked back towards the first couch, with no staff present. At 6:45 p.m., R19 began yelling again. At 6:46 p.m., R26, still standing, bent over and picked up the magazine on the floor. At 6:46 p.m., a nursing assistant (NA) came into the day room pushing a lift past R26 to assist R19. R26 remained standing, holding the magazine. At 6:47 p.m., R26 grabbed the floor sweeper handle and caused it to fall to the floor at her feet. R26 kicked the handle with her foot and NA-F walked by, placed it back against the wall, and continued to walk down the hallway away from the day room. R26 then walked down the hallway and at 6:50 p.m., entered R53's room, whose door was open. R53 was asleep in bed with the lights off. R26 walked to the middle of R53's room, grabbed onto R53's wheelchair then attempted to open R53's dresser drawer, while no staff were present. R26 walked to R53 in her bed causing R53 to wake up telling R26, "Don't come in here. You can't come in here." R26 turned around and walked back towards R53's closet. At 6:54 p.m., the administrator entered R53's room, said hello to R26 and assisted R53 while R26 continued to wander around R53's room. At 6:55 p.m., the administrator left R53's room telling R26 to come with her as she left, leaving R26 in R53's room. At 6:56 p.m., R26 proceeded to walk down the hallway away from the day room, towards the dining room to another resident's room. Multiple staff passed R26 in the hallway but did not offer to assist her or walk with her. At 7:00 p.m. R26 returned to the day room and sat on the first	F 689		

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F 689	Continued From page 37 couch. During an interview on 3/22/23 at 11:03 a.m., NA-G stated R26 walked around by herself on the unit and occasionally needed to be redirected when she wandered into other resident rooms. NA-G stated R26 had not fallen for a long time and was not a fall risk. During an interview on 3/22/23 at 11:22 a.m., registered nurse (RN)-E stated R26 ambulated independently, and she was not aware of any recent falls. During an interview on 3/23/23 at 10:56 a.m., physical therapist (PT)-A and the director of therapy (TD) stated they last saw R26 in August of 2022. PT-A stated staff should have "eyes on her" and know when she was "up and around" because she was sporadic and verified R26's recent assessment indicated R26 required limited assistance of one staff for ambulating. The TD stated she was not aware of R26's fall on 2/19/23, and had not received a referral to re-evaluate her, but would have expected to. During an interview on 3/23/23 at 12:06 p.m. RN-G stated she tracked resident falls through the facility's fall program. RN-G stated on 2/19/23, R26 had an unwitnessed fall while ambulating in the dining room. RN-G stated R26 required an assistance of one staff for ambulation and transfers, but it was difficult because R26 was impulsive. RN-G further stated R26 used to wander into other resident rooms but had not heard of any incidents recently. During an interview on 3/23/23 at 1:17 p.m. the director of nursing (DON) stated RN-G would	F 689		

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F 689	Continued From page 38 update a resident's care plan with appropriate interventions after assessing the cause of their fall. The DON also stated she was surprised R26 had not been referred to PT after her fall on 2/19/23, and thought she should have been. The facility Fall Prevention policy dated 3/20, indicated to implement appropriate fall interventions/precautions including the "falling star" program if a resident's fall risk assessment triggered a moderate to high risk or if they had any history of falling. Resident care plans were to be reviewed for all falls and updated with any newly required interventions. Post fall care included a fall risk assessment to identify and ensure appropriate interventions were in place, obtaining a therapy evaluation and treatment order as needed, and updated the resident's care plan. The facility Post Fall Investigation and Follow Up policy dated 3/20, indicated for staff to determine the root cause of the fall as best as they can and what immediate interventions can be implemented to avoid another fall of a similar nature and to ensure all staff on duty were aware of the changes being made. Any changes were to be included in the resident's care plan and Kardex.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698		5/12/23

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F 698	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review the facility failed to assess and monitor for complications per standard of practice before and after dialysis for 1 of 1 resident (R35) reviewed for dialysis care. Findings include: R35's face sheet printed 3/23/23, included diagnoses of end stage renal disease, dependence on renal dialysis, pulmonary hypertension, atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart), heart failure, and oxygen therapy due to respiratory failure. R35's provider orders printed 3/23/23, failed to indicate any assessment of the dialysis port and care prior to and following the three times per week hemodialysis appointments. R35's care plan dated 3/23/23, stated R35 had intact cognition and required assistance of two staff for toileting and transferring into his electric wheelchair. In addition, R35 was scheduled for dialysis three times per week. During interview with R35 on 3/20/23 at 4:44p.m., R35 stated facility staff have not looked at his dialysis port prior to or after his three day per week hemodialysis appointments. During interview with registered nurse (RN)-D on 3/22/23 at 12:19 p.m., RN-D stated the expectation was nursing staff are to ensure the dialysis port dressing is assessed before and after each dialysis session and to monitor R35 for	F 698	F698 Corrective Action: R35's Dialysis treatment record and care plan have been updated to include interventions to assess and monitor for complications to dialysis port before and after dialysis treatments. Corrective Action as it applies to other residents: All resident's charts/care plans who require dialysis were reviewed to ensure monitoring is in place for complications before and after dialysis. Dialysis policy was reviewed and remains current. Licensed nursing staff were re-educated on the Dialysis care policy. Date of Completion: 5/12/23 Recurrence will be prevented by: Random chart audits will be completed to ensure the care plan addresses monitoring for complications r/t dialysis. 3 random chart audits will be completed weekly for 4 weeks, then 2 random chart audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.	

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F 698	Continued From page 40 complications such as infection and bleeding. RN-D during review of R35 electronic medical record (EMR) stated "it is not there. I am not seeing it in his EMR". During interview with health unit coordinator (HUC)-G on 3/22/23 at 12:24 p.m., HUC-G stated the facility would require a provider order to assess and monitor the dialysis port site and expected the order to be added to R35 care plan. HUC-G stated R35's care plan did not have an order to assess the dialysis port site and monitor for complications. During interview with RN-E on 3/22/23 at 12:28 p.m., RN-E stated R35's current orders and care plan failed to indicate an assessment of the dialysis site and for potential complications. During interview with director of nursing (DON) on 3/22/23 at 12:51 p.m., DON stated the expectation was for nursing staff to assess the dialysis site every shift and "especially following dialysis". DON looked at R35's EMR and stated the order "is not in there and should be". DON stated dialysis cares include assessing for "complications like bleeding and infection". Facility policy titled DIALYSIS RESIDENT-CARE OF revised on 12/13 stated: 1. The care plan should address the following: *Identify potential risks and complications of dialysis (CHF, pulmonary edema, drug toxicity, electrolyte imbalance) *Measurable goal for potential risks and complications *Monitor for complications *Frequency of monitoring vital signs, respiratory	F 698		

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F 698	Continued From page 41 distress, chest pain, headache, seizure etc. *Monitoring of shunt or access site for signs of infection *Care of the access site *Potential for infection	F 698		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide food choices to 1 of 1 residents (R11) during meal service. This had the potential to affect all 15 residents residing in the memory care unit. Findings include: R11's quarterly Minimum Data Set (MDS) dated 2/13/23, indicated R11 had moderate cognitive deficits, was independent with eating and required extensive assistance with all other activities of daily living (ADLs). R11's Care Area Assessment (CAA) dated 11/16/22, indicated R11 triggered for visual function, urinary incontinence, falls, and psychotropic medication use.	F 806	F806 Corrective Action: Staff caring for R11 were re-educated to ask about food that accommodates his preferences at mealtimes. Corrective Action as it applies to other residents: Staff to ensure each resident receives food that accommodates his/her preferences at mealtimes. The Select menu policy was reviewed and remains current. The Dining room service policy was reviewed and revised. Nursing and dietary staff were educated on select menu and dining room service policies. Date of Completion: 5/12/23	5/12/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 42 R11's care plan undated, indicated R11 had personal preferences with a goal of having his preferences followed. R11 had a potential for cognitive impairment and ranged from intact to moderate cognition. Interventions included providing R11 opportunity to make choices. R11 had potential for nutritional problems related to heart disease, edema, and legal blindness. Interventions included assisting R11 with meals. R11's care plan listed diagnoses which included heart failure, legal blindness, insomnia, and depression. During an interview on 3/20/23 at 6:10 p.m., R11 stated he was not offered choices for alternate food items during meals and "you get what you are served." R11 stated growing up, he ate what was on his plate because he was told there were people starving in the world and therefore should not complain. Review of all 15 memory care resident meal tickets dated 3/23/23, revealed no preferences were checked for the breakfast or lunch meal service for any of the memory care residents. During an interview on 3/22/23 at 1:41 p.m., nursing assistant (NA)-G stated he did not ask residents with dementia about food preferences because it was difficult for them to choose. NA-G stated many residents were unable to communicate and most residents did not ask for alternate food items. NA-E agreed, stating the memory care unit offered only one "entrée" and no alternative food choices to what was on the weekly menu. NA-E further stated R11 liked the food and would eat what he was served.	F 806	Recurrence will be prevented by: Random observational dining room audits will be completed to ensure staff are asking residents about food preferences at mealtimes. 3 random observational audits will be completed weekly for 4 weeks, then 2 random observational audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The Correction will be monitored by: The Dietary Manager, Unit Managers and Director of Nursing or Designee.	

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	245272	A. BUILDING _____ B. WING _____	C 03/23/2023

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F 806	Continued From page 43 During an observation and interview on 3/23/23 from 8:34 a.m. to 8:45 a.m., R11 was sitting in the dining room eating a bowl of creamed wheat cereal. R11 stated the cereal was fine but he would prefer oatmeal every morning. R11 then told NA-G that he was given a choice of grape juice that morning and asked NA-G if he could have grape juice every morning because it was his favorite. R11 stated he had only been offered apple or orange juice previously and since he did not like orange juice, he chose apple juice. At 8:43 a.m., NA-E placed a plate with pancakes and bacon in front of R11. NA-E poured syrup on the pancakes, then cut them up. NA-E told R11 what was on the plate and that she had put syrup on the pancakes already. R11, sounding disappointed, stated, "Did you really?" NA-E stated, "Yeah" and left. NA-E did not explain where the food items were located on R11's plate. During an interview on 3/23/23 at 10:05 a.m., R11 stated the staff poured syrup on his pancakes that morning without asking him if he wanted it first. Although R11 liked syrup, he stated he would have preferred to be asked first. R11 further stated that was the first time he had been offered grape juice. R11 was "totally surprised and pleased" because he "always" used to drink grape juice and it was his favorite. R11 also stated he was a "cheese lover" and used to make his own, but they don't serve "real" cheese, only processed. During an interview on 3/23/22 at 11:47 a.m., NA-E stated resident meal tickets were brought to the unit with the food carts. NA-E stated the cook used the meal tickets to ensure they were served the correct kind of diet, but staff did not ask the residents what their preferences were for the	F 806		

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F 806	Continued From page 44 items listed on the meal tickets. During an interview on 3/23/23 at 12:04 p.m., cook (CK)-A stated he looked at the resident meal tickets to see what kind of diet each resident received. CK-A stated the meal tickets were not used to ask residents what food preferences they wanted, and CK-A did not look at the top portion of the meal ticket. CK-A further stated the meal tickets were thrown away in the shredder after each meal service. During an interview on 3/23/23 at 11:26 a.m., the dietary manager (DM) and registered dietician (RD) stated all residents on the memory care unit had meal preference cards (meal tickets) for each meal. The RD stated residents in the memory care unit should always be offered a choice or alternative to a meal. The RD further stated if a resident was unable to communicate their preferences, the resident's representative should be asked for food preferences. The RD was unaware staff were not filling out resident meal preference cards for the residents during meals in the memory care unit. The facility Select Menu policy dated September 2019, indicated select menus would be provided to residents who chose to make menu selections. Assistance from family or staff is encouraged for residents who could not make their own choices. Designated staff were to take the resident meal orders and use pictures when available for residents who were unable to communicated verbally.	F 806		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g)	F 810		5/12/23

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F 810	Continued From page 45 §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adaptive equipment was provided as care planned to promote independent, easier eating abilities for 1 of 1 resident (R112) observed to have difficulty drinking from regular (i.e., non-handled) glassware. Findings include: R112's quarterly Minimum Data Set (MDS), dated 12/29/22, identified R112 had moderate cognitive impairment and required supervision with set-up assistance for eating. R112's Nutritional Assessment 4.0 - V2, dated 12/29/22, identified R112 consumed a regular diet with thin liquids. A section labeled, "Physical Functioning," identified R112 required set-up assistance for feeding and a checkmark was placed next to a subsection labeled, "Adaptive equipment required," which outlined, "OT [occupational therapy] recommending 2-handle cup." Further, the section of the assessment labeled, "Analysis," outlined R112 demonstrated no difficulties with chewing or swallowing and was able to feed himself " ... with meal set up and uses a 2 handled cup." R112's nutritional care plan, dated 1/12/23, identified R112 was at risk for a nutritional	F 810	F 810 Corrective action: R112 was provided a 2 handled cup at meals as per the care plan. R112 was referred to formal PT and OT to determine current needs. The care plan was updated based upon the recommendations from therapy. Corrective action as it applies to other residents: Staff responsible for providing adaptive equipment at mealtimes were re-educated on the necessity to follow the care plan as it relates to the use of adaptive equipment. A policy for adaptive equipment was developed. Nursing staff were educated on the policy. Date of Completion: 5/12/23 Recurrence will be prevented by: Random observational audits will be completed to ensure residents are provided adaptive equipment as care planned. 3 random observational audits will be completed weekly for 4 weeks, then 2 random observational audits will be completed weekly for 4 weeks. Then 1 audit for one month to ensure ongoing compliance. Results of the audits will be brought to the QAPI committee meeting for review and	

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F 810	Continued From page 46 alteration due to impaired cognition and dysphagia. The care plan listed several interventions including, "Adaptive equipment/feeding: 2-handle cups. Set up meal; cut food open containers etc." On 3/22/23 at 12:11 p.m., R112 was observed in the dining room at a table while seated in his wheelchair. R112 had been served ravioli for his meal and had regular (i.e., non-handled) cups present on the table. R112 had visible contractures of his hands which caused his fingers to bend down and inward. R112 had to pick up the regular glass filled with a clear liquid using the knuckles of his hands to bring it to his mouth, with the glass having a visible shaking motion as he lifted it from the table. R112 was able to bring the glass to his mouth and take a drink, however, did spill some fluid from the glass on the left side of his face as this was attempted. The following day, on 3/23/23 at 8:05 a.m., R112 was observed in the main dining room for the breakfast meal. At 8:10 a.m., nursing assistant (NA)-L brought a tray to R112's table and set up bowls with hot cereal present in them along with regular (i.e., non-handled) glassware with various beverages inside. A white-colored menu slip was placed on R112's table at his seat which identified various menu item(s) to be selected (i.e., juices, cereals, entrees) along with R112's name, current diet, and, "Adapt Equip: Divided Plate, 2-handle Cup." R112 was again observed to use the knuckles of both hands to pick up the glassware and adjust his napkin. In addition, registered nurse (RN)-G was present in the dining room for this observation. When interviewed on 3/23/23 at 8:22 a.m., NA-L	F 810	further recommendations. The correction will be monitored by: The Culinary Director and Unit managers or Designee.	

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F 810	Continued From page 47 explained R112 had bilateral hand contractures and, as a result, had to sometimes have staff assistance with eating. NA-L stated R112 also used "special adaptive" devices to eat and drink. When questioned on when, or if, R112 used the two-handled cups outlined on his menu slip, NA-L turned away from the surveyor and left the dining room. NA-L returned shortly afterwards with two-handled cup(s) and provided them to R112 after pouring his drinks from the regular glassware into them. At 8:30 a.m., R112 was interviewed and stated it was easier to drink from the two-handled cups. Further, R112's tablemate, who was present at this time, stated they had never seen R112 be served two-handled cups before. R112's care plan, dated 3/23/23, identified R112 had an ADL self-care performance deficit and listed a goal which read, " ... will maintain current level of function in ADL's through the review date." A series of interventions were listed which included, "EATING: Set up assistance by 1 staff to eat. Cut up foods. [R112] reports that he does not have difficulty utilizing standard cups to drink, but [two] handled cups do make it easier at times." The care plan outlined this intervention was just modified on 3/23/23; and a corresponding Care Plan History report, dated 3/23/23, identified this intervention was modified and/or added on 3/23/23 by registered nurse (RN)-G. R112's medical record was reviewed and lacked evidence the recommended adaptive equipment listed on R112's most recent nutritional assessment (dated 12/29/22), and subsequently listed on the menu slip, had been discontinued or inactivated prior to the recertification survey	F 810		

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F 810	Continued From page 48 observations. On 3/23/23 at 9:04 a.m., registered nurse manager (RN)-E verified R112's care plan and menu slip directed the use of a two-handled cup. RN-E stated they expected the floor staff to read the respective menu slip information and provide any adaptive equipment, as needed. RN-E stated they would follow up with the staff. When interviewed on 3/23/23 at 10:03 a.m., RN-G verified they updated R112's care plan with the current language after the surveyor had observed R112 to be served regular (i.e., non-handled) glassware at the breakfast meal. RN-G verified the menu slip directed the use of a two-handled cup, and they explained they were going to have an occupational therapy (OT) evaluation completed for R112's eating abilities as R112 was able to use a regular (i.e., non-handled) glass, however, verified R112 expressed it was easier to use the handled glasses when she had just spoken to him during the breakfast meal. A provided Dining Room Service policy, dated March 2023, identified staff were to check the individual name and diet on each meal ticket/card to verify the meal is served to the appropriate person. Further, staff should check items on the plate/tray to assure accuracy for therapeutic diets, texture, adaptive equipment, and consistency modifications, as needed.	F 810		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		5/12/23

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F 812	Continued From page 49 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 3 commercial food cooling devices (i.e., refrigerators, freezers) had ongoing monitoring of temperature and function to reduce the risk of potential foodborne illness; failed to ensure 1 of 2 commercial can openers was kept in a clean and sanitary manner; and failed to ensure dry goods removed from original packaging were stored in a manner to reduce the risk of cross-contamination. These findings had potential to affect all 123 residents, staff, and visitors, who consumed food prepared from the main production kitchen. Findings include: On 3/20/23 at 12:14 p.m., an initial kitchen tour was completed, and the following items were identified:	F 812	F812 Corrective Action: Staff were re-educated immediately upon identifying temperature monitoring logs were incomplete for the commercial food cooling devices. Commercial can opener was cleaned. The metallic scoop was removed immediately from flour bin. Corrective action as it applies to other residents: All commercial refrigerators, kitchen devices, and kitchen storage have been audited to ensure compliance throughout the building. The Culinary Director and supervisor were re-educated on Food Storage and Sanitation Policies. Date of Completion: 5/12/2023	

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F 812	Continued From page 50 1) A commercial Edlund can opener was attached to the counter by the oven range(s). The blade of the opener had copious amounts of a dried black debris present along the bottom of the blade, along with red and tan-colored debris present along the top of the blade. 2) A single Continental double-door style refrigerator was opened. The fridge contained prepared and covered salad dishes, a single container of a breaded meat product, and a metallic serving pan filled with diced fruit. A gauge was present which identified the temperature of the refrigerator at 36 F (Fahrenheit). A white-colored flowsheet was taped to the side of the unit which was labeled, "Temps For Coolers/Freezer in Kitchen," which outlined three columns to record a daily temperature for the walk-in cooler, walk-in freezer, and, "Kitchen #3 Cooler." This had spacing on the bottom to record the month and year of the flow sheet, and this was completed as, "Feb 2023," with the last recorded date on the flow sheet being 2/9/23 (over a month prior) when the temperatures were recorded as 37F, 0F, and 36F, respectively. The walk-in cooler and walk-in freezer were toured at this time, which identified meats, eggs, and various other products being stored inside. These units each had a thermometer and/or gauge present which identified their cooling temperature(s) at 36F and 14F, respectively, at this time. There were no other posted forms, devices, or evidence the cooling device(s) temperatures were being checked and monitored visible. 3) A series of three white-colored plastic bins were on the floor (wheeled) adjacent to the dry storage room. These were labeled for powdered	F 812	Recurrence will be prevented by: Audits will be completed 3 times per week for 8 weeks Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The correction will be monitored by: Culinary Director or Designee.	

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F 812	Continued From page 51 sugar, (regular) sugar, and, "Flour." However, the bin labeled for flour was approximately 3/4 full of white flour and a metallic, gray-colored scoop was present inside the bin and touching the flour. The handle was pointed upward from the product. On 3/21/23 at 9:37 a.m., a subsequent kitchen tour was completed. The Edlund can opener remained soiled with the same black, red and tan-colored debris which had been present the day prior; and the metallic scoop remained in the white-colored bin labeled, "Flour." In addition, the white-colored flow sheet which had been present on the Continental refrigerator unit and contained the temperature recordings (dated February 2023) was now removed and there was just an empty, plastic sleeve attached to the fridge. At 9:51 a.m., cook (CK)-B was interviewed. CK-B explained there were different numbers shifts (i.e., one, two, three) who each perform different duties for cooking and cleaning. CK-B observed and verified the can opener debris, and proceeded to scrape some of the debris off using his fingernail while explaining it should be cleaned after every use. However, CK-B was unsure when it had been last used. CK-B explained the kitchen' coolers and freezers should be checked for temperature and recorded on the flow sheet every day. CK-B then walked over to the Continental unit where the white-colored flow sheet had been attached the day prior and stated a flow sheet was usually attached to the refrigerator which was used to track and record the temperatures for each of the refrigerators and freezer, however it was missing adding, "I'm surprised not to see it." CK-B observed the metallic scoop stored inside the white-colored bin labeled, "Flour," and stated the flour was not used "all the time," so they were unsure how long the	F 812		

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F 812	Continued From page 52 scoop had been left sitting inside or stored in the flour. CK-B expressed they "can't answer that" if scoops were able to be stored in opened, powder-based product like flour or not. On 3/21/23 at 9:59 a.m., the director of nutrition (DN) joined the interview. They verified the refrigerator and freezer temperatures were not being tracked as they should and expressed it was "an area of opportunity" for them to improve on as it had been an issue "since I've been here." DN explained a plan of correction (POC) was just developed for this concern the day prior and would be implemented adding it was important to ensure cooling device temperatures were checked, monitored, and recorded to ensure food was stored correctly and "served safely." DN observed the metallic scoop being stored inside the flour and expressed it should be stored in a drawer or outside of the container in some manner. The flour was used to make cakes, deserts and for thickening items and storing the scoop inside, with multiple people touching it potentially, was a "contamination risk." DN observed the Edlund can opener attached to the counter and verified the debris being present. DN explained the device and blade should be cleaned after each use to reduce to the risk of cross-contamination to other products. DN stated there were no cleaning schedules or checklists they could provide to demonstrate when items, including the can opener, had been last cleaned or serviced adding the lack of such schedule or checklist likely contributed to the issue and caused "a lot of things to get missed." Further, DN verified all "care center" residents were served from this main production kitchen. On 3/21/23 at 2:00 p.m., registered dietitian	F 812		

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F 812	Continued From page 53 (RD)-A and RD-B were interviewed. RD-B explained their role was more on the clinical side of nutrition (i.e., care planning, assessment) and not the day-to-day kitchen function. However, RD-A and RD-B acknowledged the lack of consistent cooling device temperature checking and monitoring and expressed it should have been completed. Further, RD-A and RD-B expressed the can opener should be cleaned after each use, and scoop(s) should not be stored inside opened product to help prevent potential cross-contamination. A provided General Sanitation of the Kitchen policy, dated March 2019, identified food and nutrition service staff would maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. The policy outlined, "Frequency of cleaning for each task will be defined." An additional Employee Sanitary Practices policy, dated July 2019, identified all staff would practice safe food handling procedures. This included, "Clean and sanitize equipment and work areas after use." Further, a provided Food Safety policy, dated March 2019, identified sanitary conditions would be maintained in all storage, preparation and serving areas of the kitchen. This included, "Cleaning schedules will be posted and followed." A Edlund Service Manual - M128, undated, identified the manufacturer procedures for the S-11 commercial manual can opener. A section labeled, "Cleaning Procedure," directed the opener should be cleaned daily or after each use.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		5/12/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 54 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 883		

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	245272	A. BUILDING _____ B. WING _____	C 03/23/2023

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F 883	Continued From page 55 already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident's immunization status was verified or documented for 1 of 5 residents (R118) reviewed for immunizations. Furthermore, the facility failed to ensure the influenza vaccine was offered or received for 1 of 5 residents (R118) in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R118's admission Minimum Data Set (MDS), dated 2/8/23, indicated R118 was admitted to the facility on 2/2/23 and had moderate cognitive impairment. R118's immunization record showed no evidence of receiving, or being offered, the influenza vaccine. During an interview on 3/23/23 at 1:29 p.m., R118 stated she was not offered any vaccines when she admitted to the facility, including the influenza	F 883	F883 Corrective action: R118's immunization status was verified. R118 was offered and declined the influenza vaccine on 4/13/23. Corrective action as it applies to other residents: All residents charts were reviewed to ensure influenza and pneumococcal vaccines were offered and received if resident agrees. Influenza and Pneumococcal policies were reviewed and remain current. All licensed staff were reeducated on the Influenza and Pneumococcal policies. Date of Completion: 5/12/23 Recurrence will be prevented by: Random chart audits will be completed to ensure residents are being offered flu and pneumococcal vaccines and that they received those vaccines if eligible. 3	

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F 883	Continued From page 56 vaccine. During interview on 3/23/23 at 10:00 a.m., the infection preventionist (IP) stated she was responsible for verifying residents' immunization status through the Minnesota Immunization Information Connection (MIIC) when they were admitted to the facility. The IP stated all residents should be reviewed for immunizations and be offered the COVID, pneumococcal and influenza vaccines if needed. During review of R118's immunization record, the IP stated R118 was missing documentation on the influenza vaccine and had not been offered it at admission. During an interview on 3/23/23 at 12:44 p.m., the director of nursing (DON) stated that the IP had been responsible for reviewing immunizations and offering them to residents when needed. The DON further stated vaccines should be offered within three days of admission. A facility policy tilted Resident Vaccine-Influenza, revised on 10/1/22, indicated all patients, including those admitted to the facility during influenza season will be offered an influenza vaccine, September 1 through March 31.	F 883	random chart audits will be completed weekly for 4 weeks, then 2 random chart audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. The correction will be monitored by the: Infection Preventionist and the Director of Nursing or Designee.	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been	F 887		5/12/23

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F 887	Continued From page 57 immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding	F 887		

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F 887	Continued From page 58 the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident's COVID immunization status was verified or documented for 1 of 5 residents (R118) reviewed for immunizations. Furthermore, the facility failed to ensure the COVID vaccine was offered or received for 1 of 5 residents (R118) in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R118s admission Minimum Data Set, dated 2/8/23, indicated R118 was admitted to the facility on 2/2/23 and had moderate cognitive impairment. R118's immunization record showed no evidence of receiving, or being offered, the COVID vaccine. During an interview on 3/23/23 at 1:29 p.m., R118 stated she was not offered any vaccines when she was admitted to the facility, including the COVID vaccine. During interview on 3/23/23 at 10:00 a.m., the infection preventionist (IP) stated she was responsible for verifying residents' immunization status through the Minnesota Immunization	F 887	F887 Corrective action: R118's immunization status was verified. R118 was offered and declined the Covid 19 vaccine on 4/13/23. Corrective action as it applies to other residents: All residents were reviewed to ensure the Covid 19 vaccine was offered and received if resident agrees. COVID-19 Preparedness Plan policy was reviewed and remains current. All licensed staff were educated on the COVID-19 Preparedness Plan policy regarding Covid vaccinations. Date of Completion: 5/12/23 Recurrence will be prevented by: Random chart audits will be completed to ensure residents are being offered Covid 19 vaccine and that they received vaccines if eligible. 3 random chart audits will be completed weekly for 4 weeks, then 2 random chart audits will be completed weekly for 4 weeks. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations.	

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F 887	Continued From page 59 Information Connection (MIIC) when they were admitted to the facility. The IP stated all residents should be reviewed for immunizations and be offered the COVID, pneumococcal and influenza vaccines if needed. During review of R118's immunization record, the IP stated R118 was missing documentation on the COVID vaccine and had not been offered it at admission. During an interview on 3/23/23 at 12:44 p.m., the director of nursing (DON) stated that the IP had been responsible for reviewing immunizations and offering them to residents when needed. The DON further stated vaccines should be offered within three days of admission. A policy on vaccinations was requested, however a specific policy on COVID vaccinations was not recieved.	F 887	The correction will be monitored by the: Infection Preventionist and the Director of Nursing or Designee.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/20/23 through 3/24/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/20/23

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a comprehensive assessment and person-centered care plan was completed for 1 of 1 residents (R11) who was legally blind. Findings include: R11's quarterly Minimum Data Set (MDS) dated 2/13/23, indicated R11 had moderate cognitive deficits, was independent with eating and required extensive assistance with all other activities of daily living (ADLs). R11's diagnoses included heart failure, legal blindness, insomnia, and depression. R11's Care Area Assessment (CAA) dated 11/16/22, indicated R11 triggered for visual function, urinary incontinence, falls, and psychotropic medication use. R11's care plan undated, indicated R11 preferred	2 565	Corrected	5/12/23

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2 565	Continued From page 3 to be notified and invited to larger group activities. Interventions included providing R11 with a monthly activity calendar although R11 was legally blind and unable to read. R11 was at risk for pain related to a fall with a rib fracture. Non-pharmacological interventions included walking/ambulation and reading although R11 was non-ambulatory and was legally blind. R11's care plan also indicated R11 had impaired visual function related to being legally blind. Interventions included the following: -Administering eye medications as ordered -Scheduling consultations with the eye practitioner as needed -Monitoring and recording "factors affecting visual function including physiological (glaucoma, cataracts, color discrimination, light sensitivity), environmental (poor lighting, monochromatic color scheme), choice (refuses to wear glasses, use mag glass [magnifying glass], turn on lights) etc." -Monitor/report acute eye problems including R11's ability to perform ADLs, sudden visual loss, double vision, tunnel vision, blurred or hazy vision. -"Tell where you are placing their items. Be consistent." R11's care plan lacked indication of R11's individual preferences for the placement of his personal items, how R11 preferred his room to be arranged, R11's need for assistance with written communications, or R11's preferences for personal interactions as they related to his blindness. During an interview on 3/20/23 at 6:09 p.m., R11 was sitting in his room in a recliner with a padded arm brace on his right arm and wrist. R11 stated	2 565		

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2 565	Continued From page 4 he attempted to put the brace on but because it had multiple straps and he was unable to figure it out. R11 stated there were instructions posted on his wall, however, because he was blind, they were not helpful. R11 also stated he occasionally got frustrated during meals because some staff don't tell him where his food is on his plate or assist him to cut it up. R11 stated because there was often new staff, the "messages don't get passed down." A bedside table was to R11's left, horizontal between him and his bed. A tape player was next to him, and a speaker and his cell phone were beyond it, out of R11's reach. R11's call light was also draped across the opposite end of the table, out of R11's reach. During an observation and interview on 3/22/23 at 9:07 a.m., R11 stated he wished the large oxygen tank in the corner of his room was removed or moved next to his TV. R11 stated he had not used it for five months and it was always in his way. R11 had electronic devices plugged into an outlet on the window bench behind the tank, making them difficult to access. During an interview on 3/22/23 at 11:03 nursing assistant (NA)-G stated the NAs used a resident's Kardex to know how to care for them. NA-G also stated most of the staff in the memory care unit had worked there for a long time and were familiar with the residents. During an interview on 3/22/23, at 11:22 a.m., registered nurse (RN)-E stated staff would reference the resident's Kardex which was posted in their closet to know how to care for them and/or what their preferences were. During an interview on 3/22/23, at 12:22 p.m., RN-G stated the MDS coordinator was	2 565		

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2 565	Continued From page 5 responsible for creating resident care plans and the resident Kardex was pulled from the care plan to reflect the resident's needs. During an interview on 3/23/23 at 11:07 a.m., RN-B stated she would update resident care plans to reflect their current status during the resident's quarterly assessment or as needed. A facility policy for care planning was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident	2 830		5/12/23

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2 830	Continued From page 6 prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess, create and implement intervention to promote the safety for 1 of 1 residents (R26) who resided in the memory care unit, had an unwitnessed fall, and continued to ambulate without assistance. Findings include: R26's quarterly Minimum Data Set (MDS) dated 1/30/23, indicated R26 was unable to complete the Brief Interview for Mental Status (BIMS). The staff assessment indicated R26 had severe cognitive deficits. R26 was independent for eating and required extensive assistance of one staff for all other activities of daily living (ADLs). R26 also required limited assistance of one person physical assist for walking. R26's facesheet indicated R26's had diagnoses including aphasia (a brain disorder affecting language and comprehension), Alzheimer's disease, dementia with behavioral disturbance, diabetes, corns and callosities (a thick, hard and painful raised bump), pain in right and left feet and toes, right and left feet hammer toes (an abnormal bend in the toes that can be painful), osteoarthritis (decreased bone density), and abnormalities of gait and mobility. R26's Care Area Assessment (CAA) dated 8/9/22, indicated R26 triggered for cognitive	2 830	Corrected	

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2 830	Continued From page 7 loss/dementia, communication, urinary incontinence, behaviors, psychotropic drug use, and falls. R26's care plan undated, indicated R26 was dependent on staff for meeting her social, physical, emotional, and intellectual needs and enjoyed walking independently, and with staff, around the unit. Interventions indicated R26 liked holding hands with staff. R26 had an ADL self-care deficit related to advanced dementia and aphasia. Interventions included a hand-hold assist of one in the ambulation program for walking R26 to and from the bathroom and meals and ambulating with R26 in the hallway 2-3 times per day if she did not go to meals. R26 may attempt to transfer independently due to poor memory and required a stand-by assist for ambulation and set-up with cues when moving between surfaces. R26 had limited physical mobility related to dementia, weakness, and a history of falls. Interventions included assistance of one staff for locomotion using a wheelchair, although R26 did not use a wheelchair. The care plan also indicated R26 had a communication deficit. R26 did not speak and was unable to make her needs known, making it difficult to know her comprehension. R26 was also at risk for falls related to confusion, impulsivity, being unaware of her safety needs and incontinence. Interventions included anticipating her needs, frequent checks when R26 is in bed, providing a safe environment with even floors free from clutter, adequate lighting, accessible call light, low positioned bed, and transferring R26 to the couch or chair when sitting in the lounge. R26 had a potential for mood alteration related to hallucinations. R26's Nurse Report Sheet undated, indicated R26 was on a walking program.	2 830		

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2 830	Continued From page 8 R26's Physical Therapy Evaluation and Plan of Treatment dated 7/14/22, indicated R26 was referred to physical therapy on 7/14/22, after a fall the previous week. R26's Physical Therapy Discharge Summary dated 8/11/22, indicated R26 required supervision or touching assistance for all transfers, ambulation, and picking up objects. R26's quarterly Fall Risk Assessment dated 1/27/23, indicated R26 had a score of 13 where a total score greater than 10 indicated R26 was a "HIGH RISK" for potential falls. R26's post-fall Fall Risk Assessment dated 2/24/23, indicated R26 scored a 13 and was a "HIGH RISK" for potential falls. Although R26 had a fall on 2/19/23, the risk assessment indicated R26 had "no fall in the previous three months" and decreased muscular coordination. R26's task documentation dated 3/8/23 to 3/21/23, indicated R26 moved independently between locations in her room and adjacent corridor as follows: -3/8/23, at 3:34 p.m. -3/13/23, at 2:58 p.m. -3/17/23, at 1:10 p.m. -3/18/23, at 1:59 p.m. -3/19/23, at 9:46 p.m. -3/21/23, at 1:37 p.m. During a continuous observation in the memory care unit on 3/20/23 from 6:32 p.m. to 7:00 p.m., R26 was sitting on a couch in the day room while R19 slept in a recliner in the corner. R26 dropped a magazine on the floor and made multiple, unsuccessful attempts to pick it up by scooting	2 830		

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2 830	Continued From page 9 forward on the couch and bending forward; no staff were present. At 6:34 p.m. after rocking back and forth multiple times, R26 stood up from the couch, adjusted her sweatshirt and stepped forward on her left foot, rocking back and forth and staring at the magazine on the floor. R26 then walked across the day room to another couch. R26 was wearing long jeans that wrapped under her heals; the right pant leg had a torn hem at the bottom that dragged on the floor. R26 continually attempted to pull her pants up as she walked. At 6:36 p.m. R26 continued to shift her weight back and forth while turning in a circle. At 6:37 p.m. R26 turned around and walked to the middle of the room, then to a chair on the other side of the first couch. R26 pulled on the chair arm, moving the chair slightly and rocked back and forth on her feet while pulling up her pants. At 6:38 p.m., R26 sat back down on the first couch. No staff were present. At 6:40 p.m., R26 began rocking back and forth on the couch and at 6:41 p.m. stood up. With no staff present, at 6:42 p.m., R26 walked out of the day room, then turned around and grabbed the handle of a floor sweeper propped in the corner of the day room which she was unable to lift. R26 turned back towards the couch and R19 began screaming "Help! Help! Help! I need help over here! Somebody help me! God almighty what the [explictive] is this!" R26 walked over to R19, turned around and walked back towards the first couch, with no staff present. At 6:45 p.m., R19 began yelling again. At 6:46 p.m., R26, still standing, bent over and picked up the magazine on the floor. At 6:46 p.m., a nursing assistant (NA) came into the day room pushing a lift past R26 to assist R19. R26 remained standing, holding the magazine. At 6:47 p.m., R26 grabbed the floor sweeper handle and caused it to fall to the floor at her feet. R26 kicked the handle with	2 830		

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2 830	Continued From page 10 her foot and NA-F walked by, placed it back against the wall, and continued to walk down the hallway away from the day room. R26 then walked down the hallway and at 6:50 p.m., entered R53's room, whose door was open. R53 was asleep in bed with the lights off. R26 walked to the middle of R53's room, grabbed onto R53's wheelchair then attempted to open R53's dresser drawer, while no staff were present. R26 walked to R53 in her bed causing R53 to wake up telling R26, "Don't come in here. You can't come in here." R26 turned around and walked back towards R53's closet. At 6:54 p.m., the administrator entered R53's room, said hello to R26 and assisted R53 while R26 continued to wander around R53's room. At 6:55 p.m., the administrator left R53's room telling R26 to come with her as she left, leaving R26 in R53's room. At 6:56 p.m., R26 proceeded to walk down the hallway away from the day room, towards the dining room to another resident's room. Multiple staff passed R26 in the hallway but did not offer to assist her or walk with her. At 7:00 p.m. R26 returned to the day room and sat on the first couch. During an interview on 3/22/23 at 11:03 a.m., NA-G stated R26 walked around by herself on the unit and occasionally needed to be redirected when she wandered into other resident rooms. NA-G stated R26 had not fallen for a long time and was not a fall risk. During an interview on 3/22/23 at 11:22 a.m., registered nurse (RN)-E stated R26 ambulated independently, and she was not aware of any recent falls. During an interview on 3/23/23 at 10:56 a.m., physical therapist (PT)-A and the director of	2 830		

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2 830	Continued From page 11 therapy (TD) stated they last saw R26 in August of 2022. PT-A stated staff should have "eyes on her" and know when she was "up and around" because she was sporadic and verified R26's recent assessment indicated R26 required limited assistance of one staff for ambulating. The TD stated she was not aware of R26's fall on 2/19/23, and had not received a referral to re-evaluate her, but would have expected to. During an interview on 3/23/23 at 12:06 p.m. RN-G stated she tracked resident falls through the facility's fall program. RN-G stated on 2/19/23, R26 had an unwitnessed fall while ambulating in the dining room. RN-G stated R26 required an assistance of one staff for ambulation and transfers, but it was difficult because R26 was impulsive. RN-G further stated R26 used to wander into other resident rooms but had not heard of any incidents recently. During an interview on 3/23/23 at 1:17 p.m. the director of nursing (DON) stated RN-G would update a resident's care plan with appropriate interventions after assessing the cause of their fall. The DON also stated she was surprised R26 had not been referred to PT after her fall on 2/19/23, and thought she should have been. The facility Fall Prevention policy dated 3/20, indicated to implement appropriate fall interventions/precautions including the "falling star" program if a resident's fall risk assessment triggered a moderate to high risk or if they had any history of falling. Resident care plans were to be reviewed for all falls and updated with any newly required interventions. Post fall care included a fall risk assessment to identify and ensure appropriate interventions were in place, obtaining a therapy evaluation and treatment	2 830		

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2 830	Continued From page 12 order as needed, and updated the resident's care plan. The facility Post Fall Investigation and Follow Up policy dated 3/20, indicated for staff to determine the root cause of the fall as best as they can and what immediate interventions can be implemented to avoid another fall of a similar nature and to ensure all staff on duty were aware of the changes being made. Any changes were to be included in the resident's care plan and Kardex. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which	2 890		5/12/23

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2 890	Continued From page 13 provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident with limited mobility and on a walking program received appropriate assistance to maintain or improve mobility for 1 of 1 residents (R78) reviewed for mobility. Findings include: R78's admission Minimum Data Set (MDS), dated 2/28/23, indicated R78 had mild cognitive impairment, needed limited physical assistance from one staff member for most activities of daily living (ADLs) including walking, and medical diagnoses which included aspiration pneumonia due to inhalation of food or fluids, adult failure to thrive (a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and unspecified dementia. R78's care plan indicated R78 had limited physical mobility related to weakness and was on a nursing restorative walking program. The care plan indicated R78 was independent with	2 890	Corrected	

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2 890	Continued From page 14 ambulation in her room but needed assistance from one staff member to ambulate on the unit, two times a day. R78's ambulation program documentation indicated R78 had been walked 3 times in the past nine days, once a day on 3/14/23, 3/16/23, and 3/17/23. During observation on 3/20/23, at 6:49 p.m. R78 was laying in bed, in her room alone. During observation on 3/21/23, at 2:56 p.m. R 78 was laying in bed without staff interaction. During an interview on 3/20/23, at 6:15 p.m. R78's family member (FM)-N stated R78 had finished with physical therapy and nobody was walking her anymore. FM-N stated she had asked multiple nurses to walk R78 and had received a different answer each time as to why they were not walking R78. One nurse stated R78 could ask the staff to walk with her and another nurse stated therapy would need to be consulted. FM-N further voiced concerns R78 was going to, "lose all of her gains from therapy" and was isolated to her room as she was not "allowed" to ambulate in the hallways alone. During an interview on 3/22/23, at 10:27 a.m. nursing assistant (NA)-M and NA-N stated R78 was able to ambulate in her room on her own but not in the hallway on the unit. NA-N further stated, "we only walk her if she asks us to." NA-M stated they use the Kardex to know how to care for a resident. The information from the Kardex is pulled from the resident's care plan. During an interview on 3/22/23, at 12:22 p.m. registered nurse (RN)-G stated R78 was on a	2 890		

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2 890	Continued From page 15 walking program and the expectation was the nursing assistants walk up and down the unit hall with R78 twice a day During an interview on 3/22/23, at 1:24 p.m. RN-F stated if a resident was consistently not participating in a walking program, or it was not being done, the resident would be re-evaluated for therapy. RN-F stated the staff document when they walk with residents on an ambulation program under the ambulation program task in the electronic medical record (EMR). When reviewing how often R78 was being ambulated, RN-F stated, "Oh, I should have caught that by now," and indicated R78 should be re-evaluated for therapy due to lack of documented ambulation with R78. During an interview on 3/23/23, at 12:44 p.m. the director of nursing (DON) stated the expectation for walking programs was to keep the nurse manager, (RN-F), informed if a resident was not participating in the program. The resident would then be reevaluated for therapy if needed. A facility policy titled Ambulation, revised on 12/17 indicated it was the policy of the facility to assist residents to achieve optimum ambulation function as long as possible and the nursing assistance should use the care plan for instructions on how and how often to ambulate a resident. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could provide education to all nursing staff regarding walking program recommendations and whose responsibility it is to complete walking programs for residents. Additionally, DON or designee could audit charts to ensure that all walking program recommendations have been added to care plans	2 890		

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2 890	Continued From page 16 and that care plans are followed so residents receive the required therapies. Further audits could be done of documentation of ambulation to see if care plans are being followed. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 890		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on interview, observation, and document review, the facility failed to provide shaving assistance for 2 of 2 residents (R72, R78), and failed to provide scheduled baths for 1 of 1 resident (R87) reviewed for activities of daily living (ADL).	2 915	Corrected	5/12/23

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2 915	Continued From page 17 Findings include: R72's admission Minimum Data Set (MDS) dated 3/3/23, indicated R72 had moderate cognitive impairment, required extensive assistance with most activities of daily living (ADLs), and had medical diagnosis of diabetes type II and urinary tract infection. R72's care plan indicated R72 had an ADL self-care deficit and required assistance from one staff member to complete personal hygiene. During observation on 3/20/23, at 3:37 p.m. R72 was noted to have long chin hairs approximately one inch long. During observation on 3/21/23, at 2:55 p.m. R72 was noted to have long chin hairs approximately one inch long. During observation and interview on 3/22/23, at 7:29 a.m. R72 still had long chin hairs after receiving a shower by facilty staff that morning. R72 stated the desire to have long chin hairs to be cut or shaved. however the facility failed to offer or assist with being shaved. During an interview on 3/22/23, at 10:27 a.m. nursing assistant (NA)-M stated we shave residents in the shower and will generally "shave the men but not the women". NA-N stated they should offer to shave all residents who have facial hair. During an interview on 3/22/23, at 12:22 p.m. registered nurse (RN)-G stated the expectation was for the nursing assistants to offer to shave facial hair when assisting with personal hygiene.	2 915		

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2 915	Continued From page 18 R87's admission MDS, dated 2/28/23, indicated R87 was cognitively intact, needed assistance with personal hygiene and bathing from one staff member, and had medical diagnoses of weakness, acute respiratory failure, congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should producing symptoms such as shortness of breath, fatigue, swollen legs, and rapid heartbeat) and chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems). R87's care plan, indicated R87 had an ADL self-care deficit and required assistance from one staff member with showers, personal hygiene and oral care. R87's shower tasks in the electronic medical record (EMR), indicated R87 received two showers since admission, one on 2/27/23 and another on 3/13/23. During an interview on 03/21/23, at 8:31 a.m. R 87 stated staff refused to shower him Monday evening (3/20/23), his usual shower day due to his new diagnosis of pneumonia. R87 stated staff did not offer to wash him up or give him a sponge bath. R87 further stated, "I even needed to use the toilet and they refused to bring me. I had to use my urinal on my own." During observation and interview on 3/22/23, at 8:58 a.m. R87 was in the same dirty shirt covered in ffod debris as yesterday. R87 stated staff had not offered to, or washed him up, since he missed his shower on Monday.	2 915		

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2 915	Continued From page 19 During an interview on 3/22/23, at 9:10 a.m. RN-G stated it would be expected the staff offer to give a bed bath, instead of a shower, to someone on isolation precautions for pneumonia. RN-G further stated staff did not reprot R87 missed his shower, and would expect staff to reprot anytime a shower or bath is missed. A facility policy titled, "AM Cares", revised on 10/21, indicated the staff should shave women's and men's facial hair. A policy on bathing was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure all residents are assisted with grooming needs as required to maintain or improve activities of daily living (ADL) abilities. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	2 920		5/12/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure staff could communicate effectively to 1 of 1 resident (R51), a non-English speaking resident, reviewed for communication. Findings include: R51's quarterly Minimum Data Set (MDS) dated 2/1/23, indicated moderate cognitive impairment, the preferred language was Vietnamese and needed/wanted an interpreter for communication. The MDS further indicated no behaviors, R51 required assistance of two staff for bed mobility and transfers, and assistance of one staff for eating, toileting and personal hygiene. R51's care plan updated 2/13/23, indicated to utilize Vietnamese interpreter as needed and at times, use interpreter to help with communication barriers but lacked indication when interpreter services were required. The care plan indicated R51 had a communication resource book to use with pictures and words in Vietnamese. When interviewed on 3/20/23, at 6:33 p.m. FM-E with FM-F on the phone, stated staff cannot communicate with R51 in her language, does not utilize a language line, and asks family to communicate with (R51), "For critical things." When observed on 3/21/23, at 09:20 a.m. the wall across from administration offices next to the front entry displayed a poster with the free language line numbers listed. The poster indicated the numbers were available 24 hours a day, seven days a week.	2 920	Corrected	

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2 920	Continued From page 21 When observed on 3/21/23, at 9:39 a.m. trained medication aide (TMA)-A fed R51 and asked R51 in English if she had pain. R51 touched her forehead and stated, "Yes." TMA-A did not utilize the communization resource book to identify pain. When interviewed on 3/22/23, at 7:54 a.m. nursing assistant (NA)-A stated when staff could not communicate with R51, staff asked the family for help or could request an interpreter but did not know how long it would take to get an interpreter on the phone. NA-A stated staff did not get R51 up in the mornings anymore because R51 did not want to get up, but did not know when R51 was last asked, did not ask himself, and did not know why there was a note on the wall which instructed staff to get R51 up in the mornings. When observed on 3/22/2, at 8:55 a.m. registered nurse (RN)-A and NA-A repositioned R1 and replaced dirty linens. A sign on the wall indicated get R51 up in her chair for breakfast daily and another sign indicated place walker near the bedside. There was a hand-written list of a few common phrases on the wall to use with R51 written in English and Vietnamese. The print was not visible from R51's bed, however, there were a few common phrases posted on the wall written in larger print. RN-A asked R51 in English if she had pain and asked R51 to rate it on a scale of zero to five. R51 indicated five the first time. RN-A asked again and R51 indicated three the second time. RN-A did not use the communication resource book with R51 to more accurately assess her pain. When interviewed on 3/22/23, at 8:55 a.m. RN-A stated R51 understood some communication with staff and staff could point to the phrases on the wall to aid in communication. RN-A stated staff	2 920		

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2 920	Continued From page 22 utilized family to help schedule appointments, like dental, and when there were medication changes staff asked family to explain them to R51. RN-A further stated she did not know for certain if R51 understood the question about pain. and the pain assessment did not seem accurate as R51 indicated two different pain ratings, so staff used R51's facial expressions to assess pain sometimes. When interviewed on 3/22/23, at 8:55 a.m. NA-A, who also works as a TMA, stated staff had given R51's family members medication to administer when R51 would not take it and had not used the communication resource book to communiate with R51 to explain the medications to R51. When observed and interviewed on 3/22/23, at 9:02 a.m. licensed practical nurse (LPN)-A with RN-A observing, performed a pain assessment by wrapping both arms around the body in a hugging position and swaying the body side to side, then asked R51, "Pain?" R51 replied yes. LPN-A stated she was not sure the resident understood the question, so LPN-A used a counting method in which LPN-A held up five fingers and pointed to each finger while counting to five in English. R51 repeated each number as LPN-A stated them. After the number five, LPN-A asked R51, "Five, is it five?" R51 stated, "Yes." LPN-A acknowledged uncertainty if R51 understood the pain assessment and stated, "Sometimes we call the family to assess the pain and sometimes interpreters come for general assessments." LPN-A further stated staff could acquire a facial grimaces chart to assess pain, but did not know how to teach R51 to use it. LPN-A stated staff could ask the family for help or request an interpreter from the social services staff. LPN-A further stated the facility had a	2 920		

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2 920	Continued From page 23 language line and blue phones staff could use to call an interpreter however, didn't know why R51 didn't have a blue phone in her room. When interviewed on 3/22/23, at 11:46 a.m. RN-B stated pain assessments for the MDS were performed by asking R51 if she had pain and if R51 had little or no response, would wait until an interpreter could come for a scheduled assessment. RN-B stated it was not often asking R51 about her pain for the MDS assessment would provide a good assessment or pain interview and had never utilized the language line or the communication resource book for the pain assessment. When interviewed on 3/22/23, at 11:54 a.m. social worker (SW)-A stated SW staff utilized a specific list of interpreters who knew R51 well, as listed in the medical record for assessments. SW-A stated staff had a blue phone (language line phone) for residents who required an interpreter for communication and the phone should have been in the room. SW-A stated her back-up plan for communication when the interpreter was not available was to utilize R51's daughter as an interpreter, but preferred a formal interpreter to ensure information was shared appropriately to R51. SW-A stated when R51 spoke, "Sometimes her yes/ no answers can be wrong, sometimes she can talk about something totally off track, and mumbles." "We have a communication book for her as well." SW-A stated the interpreters trained SW staff how to use the communication resource book with R51, SW staff had in turn given activity staff some sentences to utilize to communicate with R51, and further stated the communication resource book was located in the nightstand drawer in R51's room for all staff to utilize. SW-A stated	2 920		

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2 920	Continued From page 24 would work with an interpreter to develop words and pictures for R51's medication list and medication administration but nursing staff had not indicated it was a problem. Additionally, SW-A stated sometimes R51 did not answer questions when asked. When observed on 3/22/23, at 11:56 a.m. the communication resource book contained pictures with names of different foods, pictures of different activities, and words and pictures to describe pain in both English and Vietnamese. When interviewed on 3/22/23, at 12:20 p.m. nurse practitioner (NP)-C stated NP communication during assessments was completed using an interpreter, but staff communication with R51 could be better. When interviewed on 3/23/23, at 10:00 a.m. R51's interpreter stated there were no staff who spoke to R51 in Vietnamese, but R51 preferred to communicate in Vietnamese and responded best to simple one-sentence or yes/no questions. The interpreter further stated R51 often chose not to respond to staff when they tried to communicate with her. When interviewed on 3/22/23, at 10:00 a.m. with the interpreter, R51 stated she is hungry most of the time and would like to get out of bed in the mornings like she used to, but then changed her answer to no she would not like to get out of bed. R51 stated she had no pain at the time, but sometimes the pain was up to a rating of ten on a scale of zero to ten, in her head, knees, or legs. R51 stated staff does not use the communication resource book with her. R51 did not answer some of the questions asked through the interpreter, instead looked away.	2 920		

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2 920	Continued From page 25 When interviewed on 3/22/23, at 10:32 a.m. RN-A stated staff could try to use the communication resource book with R51, but it was still difficult to communicate with R51 as she was not always consistent with her answers and showed signs of increased cognitive change. RN-A further explained R51 did not always choose to communicate with or answer staff when they tried to talk to her. The Interpreter Services policy revised 12/2016, indicated interpreter services are utilized to promote optimal communication with non-English speaking residents to ensure compliance with Title VI of the Civil Rights Act of 1964, the American Disabilities Act, and other federal and state laws that address how services are provided to persons with limited English proficiency. SUGGESTED METHOD OF CORRECTION: The director of nursing could monitor personal cares provided to residents to determine resident/staffing needs, educate staff, and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 920		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or	2 945		5/12/23

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2 945	Continued From page 26 enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adaptive equipment was provided as care planned to promote independent, easier eating abilities for 1 of 1 resident (R112) observed to have difficulty drinking from regular (i.e., non-handled) glassware. Findings include: R112's quarterly Minimum Data Set (MDS), dated 12/29/22, identified R112 had moderate cognitive impairment and required supervision with set-up assistance for eating. R112's Nutritional Assessment 4.0 - V2, dated 12/29/22, identified R112 consumed a regular diet with thin liquids. A section labeled, "Physical Functioning," identified R112 required set-up assistance for feeding and a checkmark was placed next to a subsection labeled, "Adaptive equipment required," which outlined, "OT [occupational therapy] recommending 2-handle	2 945	Corrected	

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2 945	Continued From page 27 cup." Further, the section of the assessment labeled, "Analysis," outlined R112 demonstrated no difficulties with chewing or swallowing and was able to feed himself " ... with meal set up and uses a 2 handled cup." R112's nutritional care plan, dated 1/12/23, identified R112 was at risk for a nutritional alteration due to impaired cognition and dysphagia. The care plan listed several interventions including, "Adaptive equipment/feeding: 2-handle cups. Set up meal; cut food open containers etc." On 3/22/23 at 12:11 p.m., R112 was observed in the dining room at a table while seated in his wheelchair. R112 had been served ravioli for his meal and had regular (i.e., non-handled) cups present on the table. R112 had visible contractures of his hands which caused his fingers to bend down and inward. R112 had to pick up the regular glass filled with a clear liquid using the knuckles of his hands to bring it to his mouth, with the glass having a visible shaking motion as he lifted it from the table. R112 was able to bring the glass to his mouth and take a drink, however, did spill some fluid from the glass on the left side of his face as this was attempted. The following day, on 3/23/23 at 8:05 a.m., R112 was observed in the main dining room for the breakfast meal. At 8:10 a.m., nursing assistant (NA)-L brought a tray to R112's table and set up bowls with hot cereal present in them along with regular (i.e., non-handled) glassware with various beverages inside. A white-colored menu slip was placed on R112's table at his seat which identified various menu item(s) to be selected (i.e., juices, cereals, entrees) along with R112's name, current diet, and, "Adapt Equip: Divided Plate, 2-handle	2 945		

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2 945	Continued From page 28 Cup." R112 was again observed to use the knuckles of both hands to pick up the glassware and adjust his napkin. In addition, registered nurse (RN)-G was present in the dining room for this observation. When interviewed on 3/23/23 at 8:22 a.m., NA-L explained R112 had bilateral hand contractures and, as a result, had to sometimes have staff assistance with eating. NA-L stated R112 also used "special adaptive" devices to eat and drink. When questioned on when, or if, R112 used the two-handled cups outlined on his menu slip, NA-L turned away from the surveyor and left the dining room. NA-L returned shortly afterwards with two-handled cup(s) and provided them to R112 after pouring his drinks from the regular glassware into them. At 8:30 a.m., R112 was interviewed and stated it was easier to drink from the two-handled cups. Further, R112's tablemate, who was present at this time, stated they had never seen R112 be served two-handled cups before. R112's care plan, dated 3/23/23, identified R112 had an ADL self-care performance deficit and listed a goal which read, " ... will maintain current level of function in ADL's through the review date." A series of interventions were listed which included, "EATING: Set up assistance by 1 staff to eat. Cut up foods. [R112] reports that he does not have difficulty utilizing standard cups to drink, but [two] handled cups do make it easier at times." The care plan outlined this intervention was just modified on 3/23/23; and a corresponding Care Plan History report, dated 3/23/23, identified this intervention was modified and/or added on 3/23/23 by registered nurse (RN)-G.	2 945		

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2 945	Continued From page 29 R112's medical record was reviewed and lacked evidence the recommended adaptive equipment listed on R112's most recent nutritional assessment (dated 12/29/22), and subsequently listed on the menu slip, had been discontinued or inactivated prior to the recertification survey observations. On 3/23/23 at 9:04 a.m., registered nurse manager (RN)-E verified R112's care plan and menu slip directed the use of a two-handled cup. RN-E stated they expected the floor staff to read the respective menu slip information and provide any adaptive equipment, as needed. RN-E stated they would follow up with the staff. When interviewed on 3/23/23 at 10:03 a.m., RN-G verified they updated R112's care plan with the current language after the surveyor had observed R112 to be served regular (i.e., non-handled) glassware at the breakfast meal. RN-G verified the menu slip directed the use of a two-handled cup, and they explained they were going to have an occupational therapy (OT) evaluation completed for R112's eating abilities as R112 was able to use a regular (i.e., non-handled) glass, however, verified R112 expressed it was easier to use the handled glasses when she had just spoken to him during the breakfast meal. A provided Dining Room Service policy, dated March 2023, identified staff were to check the individual name and diet on each meal ticket/card to verify the meal is served to the appropriate person. Further, staff should check items on the plate/tray to assure accuracy for therapeutic diets, texture, adaptive equipment, and consistency modifications, as needed.	2 945		

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2 945	Continued From page 30 SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to assistance with eating and provide staff education related to the care of residents who use assistive devices to promote independence. The director of nursing or designee could develop an audit tool to ensure appropriate appropriate assistance and equipment are provided to promote resident independence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide food choices to 1 of 1 residents (R11) during meal service. This had the potential to affect all 15 residents residing in the memory care unit. Findings include:	2 965	Corrected	5/12/23

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2 965	Continued From page 31 R11's quarterly Minimum Data Set (MDS) dated 2/13/23, indicated R11 had moderate cognitive deficits, was independent with eating and required extensive assistance with all other activities of daily living (ADLs). R11's Care Area Assessment (CAA) dated 11/16/22, indicated R11 triggered for visual function, urinary incontinence, falls, and psychotropic medication use. R11's care plan undated, indicated R11 had personal preferences with a goal of having his preferences followed. R11 had a potential for cognitive impairment and ranged from intact to moderate cognition. Interventions included providing R11 opportunity to make choices. R11 had potential for nutritional problems related to heart disease, edema, and legal blindness. Interventions included assisting R11 with meals. R11's care plan listed diagnoses which included heart failure, legal blindness, insomnia, and depression. During an interview on 3/20/23 at 6:10 p.m., R11 stated he was not offered choices for alternate food items during meals and "you get what you are served." R11 stated growing up, he ate what was on his plate because he was told there were people starving in the world and therefore should not complain. Review of all 15 memory care resident meal tickets dated 3/23/23, revealed no preferences were checked for the breakfast or lunch meal service for any of the memory care residents. During an interview on 3/22/23 at 1:41 p.m., nursing assistant (NA)-G stated he did not ask residents with dementia about food preferences	2 965		

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2 965	Continued From page 32 because it was difficult for them to choose. NA-G stated many residents were unable to communicate and most residents did not ask for alternate food items. NA-E agreed, stating the memory care unit offered only one "entrée" and no alternative food choices to what was on the weekly menu. NA-E further stated R11 liked the food and would eat what he was served. During an observation and interview on 3/23/23 from 8:34 a.m. to 8:45 a.m., R11 was sitting in the dining room eating a bowl of creamed wheat cereal. R11 stated the cereal was fine but he would prefer oatmeal every morning. R11 then told NA-G that he was given a choice of grape juice that morning and asked NA-G if he could have grape juice every morning because it was his favorite. R11 stated he had only been offered apple or orange juice previously and since he did not like orange juice, he chose apple juice. At 8:43 a.m., NA-E placed a plate with pancakes and bacon in front of R11. NA-E poured syrup on the pancakes, then cut them up. NA-E told R11 what was on the plate and that she had put syrup on the pancakes already. R11, sounding disappointed, stated, "Did you really?" NA-E stated, "Yeah" and left. NA-E did not explain where the food items were located on R11's plate. During an interview on 3/23/23 at 10:05 a.m., R11 stated the staff poured syrup on his pancakes that morning without asking him if he wanted it first. Although R11 liked syrup, he stated he would have preferred to be asked first. R11 further stated that was the first time he had been offered grape juice. R11 was "totally surprised and pleased" because he "always" used to drink grape juice and it was his favorite. R11 also stated he was a "cheese lover" and used to make his own, but they don't serve "real" cheese, only	2 965		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 33 processed. During an interview on 3/23/22 at 11:47 a.m., NA-E stated resident meal tickets were brought to the unit with the food carts. NA-E stated the cook used the meal tickets to ensure they were served the correct kind of diet, but staff did not ask the residents what their preferences were for the items listed on the meal tickets. During an interview on 3/23/23 at 12:04 p.m., cook (CK)-A stated he looked at the resident meal tickets to see what kind of diet each resident received. CK-A stated the meal tickets were not used to ask residents what food preferences they wanted, and CK-A did not look at the top portion of the meal ticket. CK-A further stated the meal tickets were thrown away in the shredder after each meal service. During an interview on 3/23/23 at 11:26 a.m., the dietary manager (DM) and registered dietician (RD) stated all residents on the memory care unit had meal preference cards (meal tickets) for each meal. The RD stated residents in the memory care unit should always be offered a choice or alternative to a meal. The RD further stated if a resident was unable to communicate their preferences, the resident's representative should be asked for food preferences. The RD was unaware staff were not filling out resident meal preference cards for the residents during meals in the memory care unit. The facility Select Menu policy dated September 2019, indicated select menus would be provided to residents who chose to make menu selections. Assistance from family or staff is encouraged for residents who could not make their own choices. Designated staff were to take the resident meal	2 965		

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2 965	Continued From page 34 orders and use pictures when available for residents who were unable to communicated verbally. SUGGESTED METHOD OF CORRECTION: The Dietary Director and/or Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure each resident receives food that accommodates his/her preferences. The Dietary Director and/or Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Dietary Director and/or Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 3 commercial food cooling devices (i.e., refrigerators, freezers) had ongoing monitoring of temperature and function to reduce the risk of potential foodborne illness; failed to ensure 1 of 2	21015	Corrected	5/12/23

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21015	Continued From page 35 commercial can openers was kept in a clean and sanitary manner; and failed to ensure dry goods removed from original packaging were stored in a manner to reduce the risk of cross-contamination. These findings had potential to affect all 123 residents, staff, and visitors, who consumed food prepared from the main production kitchen. Findings include: On 3/20/23 at 12:14 p.m., an initial kitchen tour was completed, and the following items were identified: 1) A commercial Edlund can opener was attached to the counter by the oven range(s). The blade of the opener had copious amounts of a dried black debris present along the bottom of the blade, along with red and tan-colored debris present along the top of the blade. 2) A single Continental double-door style refrigerator was opened. The fridge contained prepared and covered salad dishes, a single container of a breaded meat product, and a metallic serving pan filled with diced fruit. A gauge was present which identified the temperature of the refrigerator at 36 F (Fahrenheit). A white-colored flowsheet was taped to the side of the unit which was labeled, "Temps For Coolers/Freezer in Kitchen," which outlined three columns to record a daily temperature for the walk-in cooler, walk-in freezer, and, "Kitchen #3 Cooler." This had spacing on the bottom to record the month and year of the flow sheet, and this was completed as, "Feb 2023," with the last recorded date on the flow sheet being 2/9/23 (over a month prior) when the temperatures were recorded as 37F, 0F, and 36F, respectively. The walk-in cooler and walk-in freezer were toured at	21015		

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21015	Continued From page 36 this time, which identified meats, eggs, and various other products being stored inside. These units each had a thermometer and/or gauge present which identified their cooling temperature(s) at 36F and 14F, respectively, at this time. There were no other posted forms, devices, or evidence the cooling device(s) temperatures were being checked and monitored visible. 3) A series of three white-colored plastic bins were on the floor (wheeled) adjacent to the dry storage room. These were labeled for powdered sugar, (regular) sugar, and, "Flour." However, the bin labeled for flour was approximately 3/4 full of white flour and a metallic, gray-colored scoop was present inside the bin and touching the flour. The handle was pointed upward from the product. On 3/21/23 at 9:37 a.m., a subsequent kitchen tour was completed. The Edlund can opener remained soiled with the same black, red and tan-colored debris which had been present the day prior; and the metallic scoop remained in the white-colored bin labeled, "Flour." In addition, the white-colored flow sheet which had been present on the Continental refrigerator unit and contained the temperature recordings (dated February 2023) was now removed and there was just an empty, plastic sleeve attached to the fridge. At 9:51 a.m., cook (CK)-B was interviewed. CK-B explained there were different numbers shifts (i.e., one, two, three) who each perform different duties for cooking and cleaning. CK-B observed and verified the can opener debris, and proceeded to scrape some of the debris off using his fingernail while explaining it should be cleaned after every use. However, CK-B was unsure when it had been last used. CK-B explained the kitchen' coolers and freezers should be checked for	21015		

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21015	Continued From page 37 temperature and recorded on the flow sheet every day. CK-B then walked over to the Continental unit where the white-colored flow sheet had been attached the day prior and stated a flow sheet was usually attached to the refrigerator which was used to track and record the temperatures for each of the refrigerators and freezer, however it was missing adding, "I'm surprised not to see it." CK-B observed the metallic scoop stored inside the white-colored bin labeled, "Flour," and stated the flour was not used "all the time," so they were unsure how long the scoop had been left sitting inside or stored in the flour. CK-B expressed they "can't answer that" if scoops were able to be stored in opened, powder-based product like flour or not. On 3/21/23 at 9:59 a.m., the director of nutrition (DN) joined the interview. They verified the refrigerator and freezer temperatures were not being tracked as they should and expressed it was "an area of opportunity" for them to improve on as it had been an issue "since I've been here." DN explained a plan of correction (POC) was just developed for this concern the day prior and would be implemented adding it was important to ensure cooling device temperatures were checked, monitored, and recorded to ensure food was stored correctly and "served safely." DN observed the metallic scoop being stored inside the flour and expressed it should be stored in a drawer or outside of the container in some manner. The flour was used to make cakes, deserts and for thickening items and storing the scoop inside, with multiple people touching it potentially, was a "contamination risk." DN observed the Edlund can opener attached to the counter and verified the debris being present. DN explained the device and blade should be cleaned after each use to reduce to the risk of	21015		

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21015	Continued From page 38 cross-contamination to other products. DN stated there were no cleaning schedules or checklists they could provide to demonstrate when items, including the can opener, had been last cleaned or serviced adding the lack of such schedule or checklist likely contributed to the issue and caused "a lot of things to get missed." Further, DN verified all "care center" residents were served from this main production kitchen. On 3/21/23 at 2:00 p.m., registered dietitian (RD)-A and RD-B were interviewed. RD-B explained their role was more on the clinical side of nutrition (i.e., care planning, assessment) and not the day-to-day kitchen function. However, RD-A and RD-B acknowledged the lack of consistent cooling device temperature checking and monitoring and expressed it should have been completed. Further, RD-A and RD-B expressed the can opener should be cleaned after each use, and scoop(s) should not be stored inside opened product to help prevent potential cross-contamination. A provided General Sanitation of the Kitchen policy, dated March 2019, identified food and nutrition service staff would maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. The policy outlined, "Frequency of cleaning for each task will be defined." An additional Employee Sanitary Practices policy, dated July 2019, identified all staff would practice safe food handling procedures. This included, "Clean and sanitize equipment and work areas after use." Further, a provided Food Safety policy, dated March 2019, identified sanitary conditions would be maintained in all storage, preparation and serving areas of the kitchen. This included, "Cleaning schedules will be posted and followed."	21015		

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21015	Continued From page 39 A Edlund Service Manual - M128, undated, identified the manufacturer procedures for the S-11 commercial manual can opener. A section labeled, "Cleaning Procedure," directed the opener should be cleaned daily or after each use. SUGGESTED METHOD OF CORRECTION: The director of nutrition (DN) or designee could develop, review and/or revise policies and procedures to ensure kitchen equipment is cleaned, and to ensure the temperatures for kitchen cooling devices are montiored and documented. The DD or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21015		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review the facility failed to safely secure medications that were left at the bedside in reach for 3 of 3 residents (R29, R20, R53) reviewed for	21565	Corrected	5/12/23

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21565	Continued From page 40 self-administration of medication (SAM). Findings include: R29's quarterly Minimum Data Set (MDS) dated 1/4/23, indicated R29 was cognitively intact. R29's Self Administration of Medications assessment dated 3/30/22, indicated R29 was not safely able to self-administer medications. R29's orders dated 6/22/22, indicated diclofenac sodium gel 1% (medication used to relieve joint pain from arthritis), apply to bilateral knees topically four times a day for knee pain. During observation on 3/20/23 at 2:00 p.m., R29 was lying in bed, sitting up with her tray table over her bed. A tube of diclofenac sodium gel 1% was within reach on R29's tray table. When interviewed on 3/20/23 at 2:00 p.m., R29 stated the diclofenac sodium gel was often left in the room, and this time since approximately 11:30 a.m. R29 stated she would have found it on the tray table for the next scheduled administration. When interviewed on 3/20/23 at 2:10 p.m., trained medication aide (TMA)-A stated R29 had gel to apply to both knees for pain, to be administered at 8 a.m. and 12 p.m. on her shift. TMA-A acknowledged she left the diclofenac sodium gel on R29's tray table and stated all R29's medications were supposed to be secured in the medication cart and not left in the room, and further stated the facility policy was to never leave medication in the rooms. R20's quarterly MDS dated 1/9/23, indicated R20 had severe cognitive deficits, required	21565		

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21565	Continued From page 41 supervision for eating, limited assistance of one staff for transfers, and extensive assistance for all other ADLs. Review of R20's facesheet documented diagnoses included dementia with behavioral disturbance, diabetes, spinal stenosis (narrowing of the spine), insomnia, spondylosis (age-related spinal fractures and/or bone spurs), anxiety, depression, right hip pain, and dysphagia (difficulty swallowing). R20's CAA dated 7/15/22, indicated R20 triggered for cognitive loss/dementia, communication, urinary incontinence, mood and behaviors, falls, psychotropic drug use, and pain. R20's care plan undated, indicated R20 was dependent on staff to meet her social, physical, emotional, and intellectual needs. R20 had an ADL self-care deficit related to weakness, pain, and impaired mobility with a history of self-transferring to the toilet. R20 also had a communication deficit related to a hearing impairment and would yell "help" instead of using her call light. Interventions included reminding R20 to use her call light. R20 also had pain related to diabetes, spinal stenosis, and her right hip. Interventions included encouraging R20 to call for pain medication and assistance with repositioning when in pain. R20's physician orders dated 6/3/20, indicated R20 received nystatin powder to her groin/abdomen related to a rash. R20's Self Administration of Medications (SAM) assessment dated 4/16/22, indicated R20 was not able to safely administer medications/products due to medical diagnoses,	21565		

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21565	Continued From page 42 decreased fine motor skills, and an inability to recognize medications. The assessment indicated the facility interdisciplinary team reviewed the assessment and agreed with the assessment. During an observation on 3/23/23 at 8:56 a.m., a bottle of nystatin powder was on R20's nightstand. During an observation and interview on 3/23/23 at 9:00 a.m., a bottle of nystatin powder was on R20's nightstand. RN-E verified the medication should not have been in R20's room if she did not have a SAM assessment that indicated R20 was safe to self-administer the medication. R53's quarterly MDS dated 1/9/23, indicated R53 had severe cognitive deficits, required supervision for eating, limited assistance for personal hygiene and extensive assistance for all other ADLs. R53's diagnoses included dementia, adjustment disorder, hallucinations, and depression. R53's care plan undated, indicated R53 had a potential for alterations in thought processes related to health decline. Interventions included monitoring for changes in R53's cognitive function, especially R53's decision-making ability, memory recall, and general awareness. R53 had a self-care deficit related to confusion. R53 had a mood problem related to depression. Interventions included offering support and encouragement as needed. R53's CAA dated 4/15/22, indicated R53 triggered for cognitive loss/dementia, visual function, communication, ADL function, and behaviors.	21565		

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21565	Continued From page 43 R53's SAM dated 11/18/22, indicated R53 was not able to safely administer medications/products due to impaired cognition and inability to recognize products. The assessment also indicated R53 and R53's representative preferred to have her medications administered by the facility. The assessment also indicated the facility interdisciplinary team reviewed the assessment and agreed with the assessment. R53's physician orders dated 12/19/22, indicated R53 received triamcinolone acetonide cream 0.1% (an anti-inflammatory). R53's orders lacked indication that R53 had a physician order for nystatin powder (anti-fungal) or miconazole cream (used to treat a fungal infection in the mouth). During an observation on 3/20/23 at 1:32 p.m., A tube of triamcinolone acetonide cream; expiration 10/24, was on R53's bedside table, and a bottle of nystatin powder; expiration 7/31/22, was on R53's nightstand next to her bed. During an observation on 3/21/23 at 1:51 p.m., R53 was sitting in a recliner with a bedside table in front of her. A tube of triamcinolone acetonide cream; expiration 10/24, was on R53's bedside table, and a bottle of nystatin powder; expiration 7/31/22, was on R53's nightstand next to her bed. R53 stated she did not know what the medications were used for. During an observation and interview on 3/22/23 at 11:55 a.m., RN-E stated medications were not to be left in resident rooms unless the resident had a SAM assessment completed that indicated the resident was safe to self-administer medications.	21565		

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21565	Continued From page 44 RN-E was unsure if R53 had a safe SAM assessment completed and removed the medications from R53's room. During an interview on 3/23/23 at 1:23 p.m., the director of nursing (DON) stated medications should not be left in resident rooms unless the resident had completed a SAM assessment and was determined to be safe to self-administer medications, especially in the memory care unit. The facility Self Administration of Medications (SAM) policy dated 6/17, indicated a SAM assessment was to be completed for any resident who requested to administer medications without the direct supervision of a nurse. Only medications permitted for self-administration were to be left at the resident's bedside and medications were not to be retained after their expiration date. SUGGESTED METHOD OF CORRECTION: The director of nurses could inservice staff regarding the process for determination of resident capability to safely self-administer medications, and to ensure mediations were not left at the bedside for residents not capable of self-administration. An audit could be conducted to identify and assess residents who have the capability to participate in self-administration. This could be part of the quality assurance plan. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21565		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights	21810		5/12/23

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21810	Continued From page 45 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring call light were accessible for 5 of 5 residents (R11, R20, R53, R61, R426). Findings include: R11's quarterly Minimum Data Set (MDS) dated 2/13/23, indicated R11 had moderate cognitive deficits, was independent with eating and required extensive assistance with all other activities of daily living (ADLs). R11's Care Area Assessment (CAA) dated 11/16/22, indicated R11 triggered for visual function, urinary incontinence, falls, and psychotropic medication use. R11's care plan undated, indicated R11 had a self-care deficit and limited mobility weakness, a history of falls with a rib fracture, and blindness. Interventions included encouraging R11 to use the call light for assistance. R11 also had a fall related to poor balance and an unsteady gait. Interventions included keeping frequently used items within his reach and encouraging R11 to call for assistance when in pain. R11 was also on	21810	Corrected	

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21810	Continued From page 46 oxygen therapy related to low oxygen levels. Interventions included an agreed upon method to call for assistance, such as a call light. R11's diagnoses included heart failure, legal blindness, insomnia, and depression. During an interview and observation on 3/20/23 at 6:10 p.m., R11 was sitting in a recliner in his room. A bedside table was to his left, horizontal between him and his bed. R11's call light was draped across the opposite end of the table, out of R11's reach. During an interview on 3/20/23 at 6:27 p.m., nursing assistant (NA)-F verified R11's call light was not within R11's reach. NA-F stated it was important for all residents to have access to their call lights so they could call for help and for R11 to know where the call light was because he could not see it. R20's quarterly MDS dated 1/9/23, indicated R20 had severe cognitive deficits, required supervision for eating, limited assistance of one staff for transfers, and extensive assistance for all other ADLs. R20's CAA dated 7/15/22, indicated R20 triggered for cognitive loss/dementia, communication, urinary incontinence, mood and behaviors, falls, psychotropic drug use, and pain. R20's care plan undated, indicated R20 was dependent on staff to meet her social, physical, emotional, and intellectual needs. R20 was experiencing flashbacks of a previous trauma that occurred in her life due to the progression of her dementia. Interventions included providing R20 with reassurance she was in a safe environment.	21810		

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	00227	A. BUILDING: _____ B. WING _____	C 03/23/2023

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21810	Continued From page 47 R20 had an ADL self-care deficit related to weakness, pain, and impaired mobility with a history of self-transferring to the toilet. R20 also had a communication deficit related to a hearing impairment and would yell "help" instead of using her call light. Interventions included reminding R20 to use her call light. R20 was at risk for falls. Interventions included keeping R20's call light within reach and providing a prompt response to R20's requests for assistance. R20 also had pain related to diabetes, spinal stenosis, and her right hip. Interventions included encouraging R20 to call for pain medication and assistance with repositioning when in pain. R20 had urinary incontinence. Interventions included toileting R20 as requested. R20's diagnoses included dementia with behavioral disturbance, diabetes, spinal stenosis (narrowing of the spine), insomnia, spondylosis (age-related spinal fractures and/or bone spurs), anxiety, depression, right hip pain, and dysphagia (difficulty swallowing). During an observation on 3/21/23 at 6:50 a.m., R26 entered R20's room while R20 was lying in bed, facing away from the door. R26's door was open; her blinds were closed, and the lights were off. R26 walked to R20's bed causing R20 to turn and tell R26 "Don't come in here! You can't come in here!" R20 turned away from R26 but remained in R26's room. R26's call light was on the floor, under her nightstand, therefore, R20 was unable to call staff for assistance. At 6:54 a.m., the administrator entered R26's room, said hello to R20 and asked R26 if she needed assistance. The administrator then placed the call light on R26's bed and left the room. R53's quarterly MDS dated 1/9/23, indicated R53 had severe cognitive deficits, required	21810		

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21810	Continued From page 48 supervision for eating, limited assistance for personal hygiene and extensive assistance for all other ADLs. R53's care plan undated, indicated R53 had a potential for alterations in thought processes related to health decline. Interventions included monitoring for changes in R53's cognitive function, especially R53's decision-making ability, memory recall, and general awareness. R53 had a self-care deficit related to confusion. R53 had a mood problem related to depression. Interventions included offering support and encouragement as needed. R53's diagnoses included dementia, adjustment disorder, hallucinations, and depression. R53's CAA dated 4/15/22, indicated R53 triggered for cognitive loss/dementia, visual function, communication, ADL function, and behaviors. During an observation and interview on 3/21/23, at 1:51 p.m. R53 sat in a recliner in her room with the call light wrapped around the grab bar of her bed, out of R53's reach. R53 stated the call light was "always" wrapped around the grab bar. R53 stated she wished she "had some manner of contacting someone," and had yelled for "a while" the previous day before someone came to help her. However, R53 stated yelling doesn't always work. R61's facesheet dated 3/23/23 stated diagnosis of Alzheimer's, heart failure, repeated falls, and rheumatoid arthritis. R61's care plan intervention dated 6/23/21 stated "Be sure call light is within reach and encourage to use it for assistance as needed".	21810		

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21810	Continued From page 49 Observation on 3/20/23, at 1:17 p.m. R61 sat in the recliner chair in her room calling out for assistance. Call light located on top of bed and not in reach of R61. During Interview on 3/20/23 at 1:20 p.m., NA-C stated R61 call light "should have been with her in reach" and verified it was not in reach of R61. Observation on 3/22/23, at 9:40 a.m. R61 sat in the recliner chair in her room with call light attached to bed rail of resident bed. Call light was not in reach of R61. During interview on 3/22/23 at 9:40 a.m., registered nurse (RN)-D confirmed the call light was not in reach of R61 and stated call light accessibility is "for her safety". During interview on 3/22/23 at 9:45 a.m., NA-D stated she was the staff member who assisted R61 to sit in her recliner this morning and "forgot" to attach the call light within reach of R61. NA-D stated "it is important she has it close for her safety". R426's admission MDS dated 3/14/23, indicated R426 had intact cognition was independent for eating, required total assistance for dressing and extensive assistance for all other ADLs. R426's diagnoses included diabetes, urinary incontinence, seizures, dementia, schizoaffective disorder, and depression. R426's CAA dated 3/14/23, indicated R426 triggered for cognitive loss/dementia, urinary incontinence, psychosocial well-being, falls,	21810		

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21810	Continued From page 50 behavioral symptoms, and psychotropic drug use. R426's care plan undated, indicated R426 was on hospice. R426 also had an ADL self-care deficit and was at risk for falls related to limited mobility and weakness. Interventions included ensuring R426's call light was within reach and R426 needed a prompt response to all requests for assistance. R426 also had a potential for pain related to wounds, limited mobility, and hospice status. Interventions included responding immediately to any complaint of pain, encouraging R426 to call for assistance when she needs to be repositioned and/or wants medication due to pain. During interview and observation on 3/21/23 at 1:33 p.m., R426 was in bed and her call light was on the floor, under her bed, not within R426's reach. R426 stated her call light was on the floor out of her reach and asked for it to be placed on her bed. During an interview on 3/21/23 at 1:38 p.m., licensed practical nurse (LPN)-B verified R426's call light was on the floor and out of R426's reach. LPN-B stated R426's call light should be clipped to her sheets and within her reach so R426 could call for help if she needed it. During interview on 3/22/23, at 12:51 p.m., director of nursing stated expectation was call lights "must be in reach of residents" at all times. Facility policy on accomodation for call lights was requested and not received. SUGGESTED METHODS OF CORRECTION:	21810		

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21810	Continued From page 51 The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/21/2023. At the time of this survey, Martin Luther Care Center 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/21/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		

Healthcare 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

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

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Martin Luther Care Center is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (000) construction. An addition, a 1-story, Type V (111) building was completed in 2010 and a 1-story, Type II (000) building was completed in 2011. The buildings will be surveyed as one building. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with

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K 000	Continued From page 2 smoke detection in the corridors, spaces open to the corridors and resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 137 beds and had a census of 126 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwells per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1, 19.2.2.3, 7.2.1.4.5.1, and 7.2.2.5.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that the door on the lower level exiting out of stairwell "A" was difficult to open exceeding 30lbf to open. 2. On 03/21/2023 between 09:30 AM and 01:00	K 225	K225 The door on stairwell A has been adjusted to open properly for egress. Chairs in stairwell A and D were moved out of the path of egress. Other paths of egress were audited to ensure there are clear pathways and all doors open appropriately. All staff will be educated on proper placement of items in hallways and paths of egress. Audits will be completed twice weekly for 8 weeks to ensure compliance. Audits will be reviewed by the safety committee and determine further action.	5/13/23

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K 225	Continued From page 3 PM, it was revealed by observation that there was a chair stored on the landing blocking the path of egress in stairwell "A". The Director of Environmental Services stated that therapy used the chair for residents. 3. On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that there was a chair stored in stairwell "D" near the door exiting out of the stairwell. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 225	The Director of Environmental Services or designee is responsible for ensuring compliance. Date Certain: 5/13/2023	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		5/13/23

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K 321	Continued From page 4 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. This deficient findings could have a patterned impact on the residents within the facility. Findings include: On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that the door to the wheelchair storage room was wedged open against the electrical panels on the wall. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 321	K321 The door to the wheelchair storage room was closed and is no longer propped open. All other doors were audited in the facility to ensure compliance. All staff will be educated on leaving doors closed if no magnet locks are in place. Audits will be completed twice weekly for 8 weeks to ensure compliance. Audits will be reviewed by the safety committee and determine further action. The Director of Environmental Services or designee is responsible for ensuring compliance. Date Certain: 5/13/2023	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 355		5/13/23

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K 355	Continued From page 5 Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that the fire extinguisher in the garage was blocked by two mini-refrigerators. 2. On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that the fire extinguisher in the art room was blocked by a table and magazine rack. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 355	K355 Refrigerators blocking the fire extinguishers have been relocated. Table and magazine rack in Art Room blocking the fire extinguisher was relocated. All staff will be educated on keeping furniture, appliances, and other items out of the pathways to access any fire extinguisher. Audits will be completed once weekly for 8 weeks to ensure compliance. Audits will be reviewed by the safety committee and determine further action. The Director of Environmental Services or designee is responsible for ensuring compliance. Date Certain: 5/13/2023	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372		5/19/23

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K 372	Continued From page 6 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that there was a penetration in the wall above the exit doors from TCU team one/ team two caused by wires. 2. On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that there was a penetration in the smoke barrier wall above the doors going into eagle crest near room 200 on the second floor. 3. On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that there was a penetration in the smoke barrier wall above the doors near B26 laundry in the basement. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 372	K372 Penetrations in the smoke barrier on TCU, above the doors near B26 laundry, and near room 200 on the second floor have been sealed per NFPA requirements. Environmental Services will audit all smoke barriers to ensure no other penetrations were present throughout the building. The facility maintenance team will be educated on standards to seal all penetrations and review standards with contractors. Audits will be completed twice weekly for 6 weeks to ensure compliance. Audits will be reviewed by the safety committee and determine further action. The Director of Environmental Services or designee is responsible for ensuring compliance. Date Certain: 5/19/2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		5/13/23

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	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 55425**

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K 918	Continued From page 7 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010	K 918	K918 Generator Load Bank testing will be scheduled and completed before date certain. The preventative maintenance tracking	

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	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2023**

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MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET BLOOMINGTON, MN 55425**

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K 918	Continued From page 8 edition), Standard for Emergency and Standby Power Systems, section 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the facility ' s Emergency Power Supply System (EPSS) was tested for at least four hours within the last 36 months. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 918	system was updated to ensure Load Bank Testing is scheduled by regulation moving forward and will be monitored by the Quality Assurance Performance Improvement (QAPI) Committee. The measures that will be taken to ensure deficiency does not reoccur is a facility review of the Emergency Generator Policy. The person responsible for compliance is the director of environmental services. Date Certain: 5/13/2023	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general	K 920		5/13/23

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	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2023**

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K 920	Continued From page 9 precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that there was a power strip plugged into another power strip in the education room. 2. On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that there was a power strip routed through holes in a cupboard with a microwave plugged into it in the therapy room. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 920	K920 The power strips have been removed from the education room and therapy gym. The maintenance team has audited the facility to ensure compliance in other areas. All staff will be educated on the power cord and extension policy in compliance with NFPA requirements. Audits will be completed once weekly for 8 weeks to ensure compliance. Audits will be reviewed by the safety committee and determine further action. The Director of Environmental Services or designee is responsible for ensuring compliance. Date Certain: 5/13/2023	
K 930 SS=D	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101	K 930		5/13/23

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	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2023**

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K 930	Continued From page 10 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain storage of liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/21/2023 between 09:30 AM and 01:00 PM, it was revealed by observation that there were two liquid oxygen containers stored in the hallway near the PS1 door. When the Director of Environmental Services and I talked with a nurse that was nearby she stated that they have been there for about a day waiting to get picked up. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 930	K930 The liquid oxygen tank that was not in use was removed from the hallway, other areas were audited to ensure no other liquid oxygen tanks. Staff will review the safe oxygen use and storage policy. An oxygen storage audit will be conducted be conducted once every week for eight weeks. The people responsible for the corrective action and monitoring of compliance include the director of environmental services and the director of nursing. Date Certain: 5/13/2023	