Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 3, 2024

Administrator
Aurora On France
6500 France Avenue
Edina, MN 55435

RE: CCN: 245634
Cycle Start Date: June 20, 2024

Dear Administrator:

On June 20, 2024, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

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

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

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

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by August 2, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Aurora On France will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 2, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Nathan Schreier, Regional Operations Supervisor
Metro B District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 20, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

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

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

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

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

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

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

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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July 3, 2024

Administrator
Aurora On France
6500 France Avenue
Edina, MN 55435

Re: State Nursing Home Licensing Orders
Event ID: BPD711

Dear Administrator:

The above facility was surveyed on June 17, 2024 through June 20, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Nathan Schreier, Regional Operations Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: nate.schreier@state.mn.us
Office: (651) 201-4348 Mobile (651) 392-2726

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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	6500 FRANCE AVENUE EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/17/24-6/20/24, a standard recertification survey was conducted at your facility. A complaint investigation was 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 cited: H56344539C (MN00086590) H56344600C (MN00089087) H56344538C (MN00086111) H56344085C (MN00103596) H56344583C (MN00086690) H56344208C (MN00103726) 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 substantial compliance with the regulations has been attained.	F 000		
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	F 656		7/30/24

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

Electronically Signed | 07/11/2024

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

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F 656	Continued From page 1 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 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.	F 656		

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F 656	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure comprehensive care plans were developed for montioring side effects in 2 of 5 residents (R4, R147) reviewed for antipsychotic drug use. Findings include: R147 had a diagnosis of dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R147's physician's orders dated 6/12/24, indicated quetiapine fumarate (Seroquel) oral tablet 25 milligrams (mg). Give 12.5 mg by mouth as needed for anxiety twice a day. R127's care plan lacked any indication of side effect montioring for antipsychotic medications. During interview on 6/20/24 at 9:50 a.m., the director of nursing stated residents who were taking an antipsychotic medication should also be monitored for side effects (on the care plan). During interview on 6/20/24 at 10:57 a.m. the Pharmacist stated she had made a recommendation on 6/18/24 to monitor for side effects, add non pharmacological interventions for psychotropics and monthly orthostatic blood pressure for R147 since she was taking an antipsychotic medication. The pharmacist also stated these recommendations should have been started at the time the antipsychotic was prescribed and while developing the care plan R4's admission Minimum Data Set (MDS) dated	F 656	F000 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance. F 656 1.Corrective Action: Residents 4, resident discharged on 7/7/2024 and 147’s records were reviewed for antipsychotic drug use on 6/20/2024. Comprehensive care plans were developed for monitoring side effects. 2.Corrective Action as it applies to other residents: All residents on antipsychotic medication will have their records reviewed to ensure their care plans have monitoring of side effects documented. The policy on Psychopharmacologic drug use was reviewed and revised. Licensed staff responsible for monitoring antipsychotic drug use were re-educated on the policy on Psychopharmacologic drug use. 3.Date of Completion: 7/30/2024 4.Reoccurrence will be prevented by: Director of Nursing or designee will	

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F 656	Continued From page 3 5/20/24, indicated R4 admitted to the facility on 5/14/24, had intact cognition, did not have behaviors, did not reject care, had depression, and took an antidepressant 7 out of 7 days. R4's Care Area Assessment (CAA) dated 5/20/24, indicated R4 had depression and took fluoxetine 40 mg every day and had an order for trazodone for insomnia and had not used the medication. Further, the CAA indicated, adverse consequences of antidepressants exhibited by R4 included an increased risk for falling and depression. R4's care plan dated 5/23/24, indicated R4 would remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood through the review date and interventions indicated to monitor, document, and report as needed any risk for harm to self, suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. The care plan lacked interventions for monitoring for side effects. R4's Physician's Orders form indicated the following orders: 5/14/24, trazodone HCl Oral Tablet (trazodone HCl) Give 50 milligrams (mg) by mouth as needed for Sleep. 5/14/24, fluoxetine HCl Oral Capsule 40 MG (Fluoxetine HCl) Give 40 mg orally one time a day	F 656	conduct chart audits to ensure patients on antipsychotic medication will have their records reviewed and ensure their care plans have monitoring of side effects documented. Audits will be completed weekly x4 weeks, then monthly x3 months. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5.The Correction will be monitored by: Director of Nursing or designee.	

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F 656	Continued From page 4 for depression. The Physician's Orders form was reviewed and lacked any monitoring for side effects. R4's Consultant Pharmacist's Medication Regimen Review form dated 5/21/24, indicated to update the care plan and kardex to include behavior, intervention and side effect monitoring for continued fluoxetine, trazodone, and atarax as needed use. During interview on 6/20/24 at 10:39 a.m., the pharmacist consultant (PC)-D stated she completed a medication review on 5/21/24 and recommended indications for medications along with updating the care plan to include behavior monitoring, non pharmacological interventions, and side effect monitoring for psychotropic medications. PC-D stated she expected staff should have already address the care plan interventions by now. During interview on 6/20/24 at 1:41 p.m., the director of nursing stated each area nurse manager printed off recommendations and gave them to the nurse practitioner and stated since the facility was a transitional care unit (TCU), they try to turn around the recommendations quickly and expected the nurse's to follow up within 5 business days. DON further stated R4 had a depression care plan to monitor for harm but stated R4 did not have anything regarding nonpharmacologic interventions and side effect monitoring for the psychotropics and stated it should be in the care plan but did not see anything in R4's care plan.	F 656		

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	245634	A. BUILDING **01 - AURORA ON FRANCE** B. WING _____	**06/18/2024**

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AURORA ON FRANCE	**6500 FRANCE AVENUE EDINA, MN 55435**

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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 06/18/2024. At the time of this survey, Aurora On France 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 | 07/11/2024

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

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	245634	A. BUILDING **01 - AURORA ON FRANCE** B. WING _____	**06/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA ON FRANCE	**6500 FRANCE AVENUE EDINA, MN 55435**

(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
K 000	Continued From page 1 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. Aurora on France is a 4-story building with a full basement that was determined to be of Type II(222) construction The skilled nursing home on the 2nd floor with customary access on the 1st floor. Each floor is divided into separate smoke compartments and has a horizontal exit dividing the building by a 2-hour fire-rated wall. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with	K 000		

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	245634	A. BUILDING **01 - AURORA ON FRANCE** B. WING _____	**06/18/2024**

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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. There is smoke detection in the resident rooms that are supervised. The 1st floor is memory care with the 3rd, and 4th stories are licensed for assisted living and have a 2-hour fire rated separation. The facility has a capacity of 63 beds and had a census of 61 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 211	K211 1. Corrective Action: Chairs were removed from the corridors. A desk was set up in a separate, non-corridor space to allow a spot for nursing assistants to sit down and document. 2. Corrective Action as it applies to other residents: Staff will be provided education	7/30/24

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K 211	Continued From page 3 1. On 06/18/2024 at 11:02 AM, it was revealed by observation that there were seven chairs in the egress corridor in the North Pod near the Northwest Stair. 2. On 06/18/2024 at 11:10 AM, it was revealed by observation that there were two chairs in the egress corridor in the South Pod near resident room 2214. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 211	to staff on not obstructing means of egress. 3. Date of Completion: 7/30/24 4. Reoccurrence will be prevented by: EVS Director or designee will conduct random audits of corridors to ensure means of egress is not obstructed. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: EVS Director or designee.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/18/2024 between 09:00 AM and 11:30 AM, it was revealed by a review of available documentation that the emergency lighting inspection and testing documentation that was provided at the time of the survey did not indicate whether the lighting was tested 30 seconds for the monthly testing or 90 minutes for the annual, so I	K 291	K291 1. Corrective Action: Both a 30 second monthly and 90 minute annual test of the emergency lighting to be completed. 2. Corrective Action as it applies to other residents: Regional Director of Facilities will train maintenance staff on competing the 30 second monthly and 90 minutes annual tests on all battery-operated emergency lights. EVS Director or designee will carry out and document each test. 3. Date of Completion: 7/30/24 4. Reoccurrence will be prevented by: EVS Director or designee will complete random audits to ensure compliance with	7/30/24

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K 291	Continued From page 4 could not verify that the annual inspection had been completed. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 291	emergency lighting requirements. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: EVS Director or designee.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) 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 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322)	K 321		7/30/24

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K 321	Continued From page 5 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 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, and 8.3.3.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/18/2024 at 10:45 AM, it was revealed by observation that the door to the soiled utility in the France Pod would get stuck on the door frame causing the door to not fully self-close. 2. On 06/18/2024 at 11:04 AM, it was revealed by observation that the door to the soiled utility room in the North Pod would not latch when testing the self-closing device. An interview with the Regional Facilities Director and the Director of Environmental Services verified these deficient findings at the time of discovery.	K 321	K321 1. Corrective Action: DJ Doors assessed the problem with the doors not closing/latching. DJ Doors have been scheduled to and will correct the doors to ensure they close and latch properly. 2. Corrective Action as it applies to other residents: Will review all doors for hazardous areas to ensure they close and latch properly. If there are any doors identified to not close/latch on their own, they will be fixed. 3. Date of Completion: 7/30/24 4. Reoccurrence will be prevented by: EVS Director or designee will compete random audits to ensure compliance with door closures for hazardous areas. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: EVS Director or designee.	
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: Based on observation and staff interview, the facility failed to maintain access to fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and	K 355	K355 1. Corrective Action: Chair in front of the fire extinguisher was removed. 2. Corrective Action as it applies to other	7/30/24

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K 355	Continued From page 6 NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/18/2024 at 11:01 AM, it was revealed by observation that there was a chair blocking the fire extinguisher near resident room 2121. An interview with the Regional Facilities Director and the Director of Environmental Services verified these deficient findings at the time of discovery.	K 355	residents: Staff will be provided education to staff on not obstructing fire extinguishers. 3. Date of Completion: 7/30/24 4. Reoccurrence will be prevented by: EVS Director or designee will conduct random audits to ensure fire extinguishers are not obstructed. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: EVS Director or designee.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,	K 363		7/30/24

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K 363	Continued From page 7 and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/18/2024 at 10:38 AM, it was revealed by observation the door to resident room 2308 was propped open with a garbage can. 2. On 06/18/2024 at 10:39 AM, it was revealed by observation that the door to the Lyndale activity room was propped open with a rubber wedge. 3. On 06/18/2024 at 10:40 AM, it was revealed by observation that the door to office 2433 was propped open with a rubber wedge. 4. On 06/18/2024 at 10:46 AM, it was revealed by observation that the door to office 2319 was propped open with a rubber wedge. 5. On 06/18/2024 at 10:50 AM, it was revealed by observation that the door to office 2311 was propped open with a rubber wedge. 6. On 06/18/2024 at 10:54 AM, it was revealed by observation that the door to the Speech Therapy office was propped open with a rubber wedge.	K 363	K363 1. Corrective Action: North Pod nursing station door was removed. Rubber wedges and garbage cans holding open doors were removed. Automatic door closers on office doors were removed to ensure doors can stay open without wedges. 2. Corrective Action as it applies to other residents: Staff will be educated on fire safety regarding propping doors open. 3. Date of Completion: 7/30/24 4. Reoccurrence will be prevented by: EVS Director or designee will conduct random audits of office doors and resident rooms to ensure they are not being propped open with rubber wedges or garbage cans. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: EVS Director or designee.	

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K 363	Continued From page 8 7. On 06/18/2024 at 10:58 AM, it was revealed by observation that there was tape covering the latch to the North Pod office door causing the door to not latch. 8. On 06/18/2024 at 11:10 AM, it was revealed by observation that the door to office 2401 was propped open with a rubber wedge. An interview with the Regional Facilities Director and the Director of Environmental Services verified these deficient findings at the time of discovery.	K 363		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1 and 5.2.4.1. This	K 761	K761 1. Corrective Action: 12 point inspection of fire doors completed. 2. Corrective Action as it applies to other residents: EVS Director was educated by Regional Director of Facilities on 12 point	7/30/24

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K 761	Continued From page 9 deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/18/2024 between 09:00 AM and 11:30 AM, it was revealed by a review of available documentation that the fire door inspection report that the facility provided at the time of the survey did not list what items were being inspected, so it could not be verified that all minimum required items were being inspected. An interview with the Regional Facilities Director and the Director of Environmental Services verified these deficient findings at the time of discovery.	K 761	fire door inspections. Education provided to Maintenance staff on process. Documentation form updated. Inspection schedule added to TELS system for alerts. 3. Date of Completion: 7/30/24 4. Reoccurrence will be prevented by: EVS Director or designee will conduct random audits of door inspections. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: EVS Director or designee.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/18/2024 between 09:00 AM and 11:30 AM,	K 901	K901 1. Corrective Action: NFPA 99 has been completed. 2. Corrective Action as it applies to other residents: Education provided to EVS Director on completion of NFPA 99 and annual review. NFPA 99 annual review added to TELS. 3. Date of Completion: 7/30/24 4. Reoccurrence will be prevented by:	7/30/24

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K 901	Continued From page 10 it was revealed by a review of available documentation that at the time of the survey the facility could not provide an NFPA 99 Risk Assesment. An interview with the Regional Facilities Director and the Director of Environmental Services verified this deficient finding at the time of discovery.	K 901	EVS Director will audit NFPA 99 annually for completion. Added to TELS. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: EVS Director or designee.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition,	K 914	K914 1. Corrective Action: Testing on all outlets to be completed by 7/30. 2. Corrective Action as it applies to other	7/30/24

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K 914	Continued From page 11 section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/18/2024 between 09:00 AM and 11:30 AM, it was revealed by a review of available documentation that the electrical outlet inspection documentation that was provided at the time of the survey did not list what outlets have been tested or what items were being tested, so it could not be verified that physical integrity, continuity, correct polarity, and retention had been tested on all resident room electrical outlets. An interview with the Regional Facilities Director and the Director of Environmental Services verified these deficient findings at the time of discovery.	K 914	residents: EVS Director was educated by Regional Director of Facilities on electrical outlet inspections. Education provided to Maintenance staff on process. Documentation form updated. Inspection reviewed in TELS system. 3. Date of Completion: 7/30/24 4. Reoccurrence will be prevented by: EVS Director or designee will conduct random audits of outlet inspections. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: EVS Director or designee.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing 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	K 918		7/30/24

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K 918	Continued From page 12 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 maintain generators 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, sections 8.4.2, 8.4.2.1, 8.4.2.3, 8.4.6.1, and 8.4.9.5.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/18/2024 between 09:00 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have completed monthly generator testing after 10/30/2023.	K 918	K918 1. Corrective Action: Documentation on testing found and sent to Fire Marshall. Generator testing was complete. 2. Corrective Action as it applies to other residents: Education provided to EVS Director on documentation of inspections. 3. Date of Completion: 7/30/24 4. Reoccurrence will be prevented by: EVS Director or designee will conduct random audits of documentation for generator inspections. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: EVS Director or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING **01 - AURORA ON FRANCE** B. WING _____	**06/18/2024**

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K 918	Continued From page 13 An interview with the Regional Facilities Director and the Director of Environmental Services verified this deficient finding at the time of discovery.	K 918		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders.	K 923		7/30/24

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K 923	Continued From page 14 When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2 and 11.6.5.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/18/2024 at 10:53 AM, it was revealed by observation that the oxygen cylinders in the France oxygen room did not have full cylinders segregated from empty cylinders. An interview with the Regional Facilities Director and the Director of Environmental Services verified this deficient finding at the time of discovery.	K 923	K923 1. Corrective Action: Signage was installed to delineate between full storage area and empty storage area. 2. Corrective Action as it applies to other residents: Nursing staff will be educated on proper storage process including maximum storage capacity and storage areas. 3. Date of Completion: 7/30/24 4. Reoccurrence will be prevented by: EVS Director or designee will complete random audits to ensure oxygen is stored properly and not over capacity. Results of the audits will be brought to the QAPI committee meeting for review and further recommendations. 5. The Correction will be monitored by: EVS Director.	

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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 6/17/24-6/20/24, 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		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H56344539C (MN00086590) H56344600C (MN00089087) H56344538C (MN00086111) H56344085C (MN00103596) H56344583C (MN00086690) H56344208C (MN00103726). NO licensing orders were issued. 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	2 000		

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2 000	Continued From page 2 State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced	2 900		7/30/24

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2 900	Continued From page 3 by: Based on observation, interview, and document review the facility failed to develop and implement interventions to prevent pressure ulcers. The facility further failed to ensure residents with current pressure ulcers were turned and repositioned timely for 1 of 2 residents (R13) reviewed for pressure ulcers. Findings include: R13's admission Minimum Data Set (MDS) dated 5/30/24, indicated moderately impaired cognition and a diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, chronic pain, and polyneuropathy. It further indicated R13 had impairment on both sides of upper and lower extremities, required substantial/maximal assistance with bed mobility, and was at risk for and had (1) unstageable facility acquired (not present on admission) deep tissue injury. R13's care area assessment (CAA) for skin was triggered and indicated the following: -at risk for skin breakdown due to decreased mobility, decreased range of motion (ROM) to upper/lower extremities, residual right hemiparesis, bowel incontinence, use of Foley catheter, and use of Apixaban 5 milligrams (mg) twice a day which may cause easy bruising. -admitted with a PICC line in his right upper arm with catheter checked for length, peripherally inserted central catheter (PICC) line dressing change per order. -deep tissue injury (DTI) to his right heel. Orders for heel protectors, barrier film twice a day with army battle dressing (ABD) and wrapped in Kerlix per order. He will be seen by wound physician's assistant on 6-6-2024. -requires assistance with bed mobility and	2 900	corrected	

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2 900	Continued From page 4 transfers, using an alternating pressure mattress (APM) and needs assistance with turning/repositioning/offloading every 2 hours and as needed. -all catheter cares done by nursing, checked/changed and offered bedpan for bowel movements, assisted with pericare, incontinent pad change, and wears an incontinent pad for his comfort. -receiving physical and occupational therapy (PT/OT) and expected to improve in some of his activiites of daily living (ADL). -Braden score is 10 and again 15, at risk, weekly skin audits. R13's admission assessment dated 5/4/24 indicated, no skin issues. R13's physician's orders dated 6/8/24 indicated, reposition every 2 hours and as needed. R13's comprehensive skin assessment dated 5/24/24 indicated, a Braden score of 10, high risk, no pressure reducing device in bed/chair, risk factors-cognitively impaired, requires assistance with ADL's, bowel incontinence, no pedal pulses, no interventions. Patient is a two assist with all ADL's and is incontinent of bowel. Nursing staff will check on the patient every hour and offer assistance with all ADL's as needed. R13's care plan dated 5/26/24 indicated, R13 had an ADL self-care performance deficit related to physical deconditioning/acute cystitis with an intervention of asssistance of (2) staff for repositioning and turning in bed. R13's care plan dated 5/31/24, further indicated R13 had an actual impairment to skin integrity and potential for further impairment to skin with an intervention to turn and reposition every 2 hours in bed and/or	2 900		

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2 900	Continued From page 5 chair. R13's progress note dated 5/29/2024, indicated pressure wound found on right heel today. See wound notes for measurements. New orders from physician's assistant which include heel protectors at all times, APM, barrier film x2 to area, allow to dry, cover with ABD and Kerlex twice daily. Message left to update son. During continuous observation and interview on 6/18/24 from 10:15 a.m. to 1:00 p.m. the following was observed/occurred: -10:15 a.m. occupational therapist (OT)-A was leaving R13's room and stated R13 required assistance to reposition and was unable to do so by himself due to severe back pain. OT-A further stated during therapy R13 had been repositioned. -10:18 a.m. R13 was laying in bed on his back with the head of bed (HOB) slightly elevated and a pillow between his right arm and the bed rail. -10:25 a.m. licensed practical nurse (LPN)-A enterd R13's room and asked what his pain level was. -10:35 a.m. LPN-A exited the room and stated while in the room, she had applied R13's pain patch to his neck, looked at/assessed his feet, fixed his watch so it wasn't pinching his skin, checked his PICC line dressing and assessed his pain level. LPN-A did not repostion R13. -10:40 a.m. speech therapist (SLP)-A entered the room -10:53 a.m. nursing assistant (NA)-A entered the room and asked R13 what he would like for lunch. -10:54 a.m. SLP-A exited the room and stated she was talking to him about the difficulty of eating certain foods and liquids. SLP-A also stated she didn't do any cares with R13. -10:55 a.m. NA-A exited room.	2 900		

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2 900	Continued From page 6 -11:08 a.m. R13 was in the same position. -11:18 a.m. R13 put on the call light, NA-A entered room, asked "How can I help you?" and then stated "Oh, you want some more water." -11:19 a.m. NA-A exited the room. -11:21 a.m. NA-A entered the room with a glass of water. -11:24 a.m. NA exited the room and stated she brought the resident some water and had to thicken it. R13 was in the same position. -11:54 a.m. R13 was in the same position. -12:04 p.m. NA-A entered room with R13's lunch tray, set it up for him, and exited at 12:05 p.m. -12:07 p.m. NA-A R13 was in the same position except the HOB was elevated to a sitting position. -12:17 p.m. same position, no staff have entered the room. -12:28 p.m. NA-A removed R13's meal tray from his room, R13 was in the same position. -12:50 p.m. R13 was in the same position, no staff have entered the room. -1:01 p.m. NA-A stated the last time R13 was repositioned was "about an hour or two ago" then she stated "Well actually I put the head of his bead back down about a half hour ago and asked him if he was comfortable, but the last time I actually turned him on his side was about two hours ago." During interview on 6/20/24 at 11:26 a.m., NA-A stated the NA's complete rounds every 2 hours which included checking/changing briefs and re-positioning, also as needed. NA-A further stated if a resident refused to have their brief changed or to re-position they try to reapproach them later and if they still refuse, they should let the nurse know and document it. During a follow up interview on 6/20/24 at 1:01 p.m., NA-A stated the last time R13 was	2 900		

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2 900	Continued From page 7 repositioned was "about an hour or two ago" then she stated "Well actually I put the head of his bead back down about a half hour ago and asked him if he was comfortable, but the last time I actually turned him on his side was about two hours ago." During interview on 6/20/24 at 7:25 a.m. LPN-B stated nurses were responsible for completing skin assessments twice a week on bath days. If they observe a new skin concern they are required to fill out a skin check form, if there are no new skin concerns they can just check it off on the treatment administration record (TAR) that it was completed. When a resident was admitted to the facility the receiving nurse was responsible for documenting if a resident was at risk for or had any skin alterations and then the nurse manager was responsible for adding interventions. It was the nurse managers responsiblity to follow up and make sure it was care planned. LPN-B further stated NA's were responsible for completing rounds every 2-3 hours which included checking/changing briefs, repositioning, and seeing if the resident needed anything. Repositioning would be considered to be when a resident was laying on their back and then would be repositioned on their side or using pillows to relieve pressure on one area of the body. Raising/lowering the HOB by itself would not be considered repsotioning a resident. NA's should report refusals by resident to reposition and the nurses should document it. During interview on 6/20/24 at 7:38 a.m., NA-E stated NA's should complete rounds every 2-3 hours and included checking/changing brieds and repositioning. NA's generally reposition residents from side to side, or onto their back if they are on their side and raising/lowering the HOB would not	2 900		

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2 900	Continued From page 8 be considered repositioning a resident. During interview on 6/20/24 at 8:20 a.m., the nurse manager registered nurse (RN)-A stated nurses and managers were expected to put in interventions on the admission assessment depending on what the receiving nurse triggered and she would expect skin interventions to be added right away upon admission, if the resident was at risk for skin breakdown. RN-A further stated re-positioning a resident would be considered side to side, onto their back, or raising the HOB and the feet, not just raising the HOB by itself. Also, asking a resident if they are comfortable dosen't mean they shouldn't be offered to be reprositioned. we want to prevent those skin breakdown. Usually in a TCU the residents need help to do those things and staff should encourage them. We want to prevent skin breakdown. RN-A also verified R13 didn't have any skin interventions added upon admission (before 5/29/24 when a pressure ulcer was noted on his heel). During interview 6/20/24 at 8:40 a.m., the director of nursing (DON) stated nurses were responsible for completing skin checks once a week on bath day and documenting it in the medical record. THe DON further stated interventions should be added right away on admission when a resident was at risk for skin breakdown. The DON would not consider raising/lowering the HOB of a resident to be repositioning. The facility's policy on the management of skin alterations dated 5/24/24, indicated on admission, readmission, quarterly, and significant change in condition, each resident will have a skin risk assessmentt and Braden assessment for determination of risk. Appropriate interventions	2 900		

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2 900	Continued From page 9 will be implemented based on assessment and will be placed on resident care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.	2 905		7/30/24

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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
2 905	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop and implement interventions to prevent pressure ulcers. The facility further failed to ensure residents with current pressure ulcers were turned and repositioned timely for 1 of 2 residents (R13) reviewed for pressure ulcers. Findings include: R13's admission Minimum Data Set (MDS) dated 5/30/24, indicated moderately impaired cognition and a diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, chronic pain, and polyneuropathy. It further indicated R13 had impairment on both sides of upper and lower extremities, required substantial/maximal assistance with bed mobility, and was at risk for and had (1) unstageable facility acquired (not present on admission) deep tissue injury. R13's care area assessment (CAA) for skin was triggered and indicated the following: -at risk for skin breakdown due to decreased mobility, decreased range of motion (ROM) to upper/lower extremities, residual right hemiparesis, bowel incontinence, use of Foley catheter, and use of Apixaban 5 milligrams (mg) twice a day which may cause easy bruising. -admitted with a PICC line in his right upper arm with catheter checked for length, peripherally inserted central catheter (PICC) line dressing change per order. -deep tissue injury (DTI) to his right heel. Orders for heel protectors, barrier film twice a day with army battle dressing (ABD) and wrapped in Kerlix per order. He will be seen by wound physician's assistant on 6-6-2024.	2 905	corrected	

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	31815	A. BUILDING: _____ B. WING _____	06/20/2024

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2 905	Continued From page 11 -requires assistance with bed mobility and transfers, using an alternating pressure mattress (APM) and needs assistance with turning/repositioning/offloading every 2 hours and as needed. -all catheter cares done by nursing, checked/changed and offered bedpan for bowel movements, assisted with pericare, incontinent pad change, and wears an incontinent pad for his comfort. -receiving physical and occupational therapy (PT/OT) and expected to improve in some of his activiites of daily living (ADL). -Braden score is 10 and again 15, at risk, weekly skin audits. R13's admission assessment dated 5/4/24 indicated, no skin issues. R13's physician's orders dated 6/8/24 indicated, reposition every 2 hours and as needed. R13's comprehensive skin assessment dated 5/24/24 indicated, a Braden score of 10, high risk, no pressure reducing device in bed/chair, risk factors-cognitively impaired, requires assistance with ADL's, bowel incontinence, no pedal pulses, no interventions. Patient is a two assist with all ADL's and is incontinent of bowel. Nursing staff will check on the patient every hour and offer assistance with all ADL's as needed. R13's care plan dated 5/26/24 indicated, R13 had an ADL self-care performance deficit related to physical deconditioning/acute cystitis with an intervention of asssistance of (2) staff for repositioning and turning in bed. R13's care plan dated 5/31/24, further indicated R13 had an actual impairment to skin integrity and potential for further impairment to skin with an intervention	2 905		

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2 905	Continued From page 12 to turn and reposition every 2 hours in bed and/or chair. R13's progress note dated 5/29/2024, indicated pressure wound found on right heel today. See wound notes for measurements. New orders from physician's assistant which include heel protectors at all times, APM, barrier film x2 to area, allow to dry, cover with ABD and Kerlex twice daily. Message left to update son. During continuous observation and interview on 6/18/24 from 10:15 a.m. to 1:00 p.m. the following was observed/occurred: -10:15 a.m. occupational therapist (OT)-A was leaving R13's room and stated R13 required assistance to reposition and was unable to do so by himself due to severe back pain. OT-A further stated during therapy R13 had been repositioned. -10:18 a.m. R13 was laying in bed on his back with the head of bed (HOB) slightly elevated and a pillow between his right arm and the bed rail. -10:25 a.m. licensed practical nurse (LPN)-A enterd R13's room and asked what his pain level was. -10:35 a.m. LPN-A exited the room and stated while in the room, she had applied R13's pain patch to his neck, looked at/assessed his feet, fixed his watch so it wasn't pinching his skin, checked his PICC line dressing and assessed his pain level. LPN-A did not repostion R13. -10:40 a.m. speech therapist (SLP)-A entered the room -10:53 a.m. nursing assistant (NA)-A entered the room and asked R13 what he would like for lunch. -10:54 a.m. SLP-A exited the room and stated she was talking to him about the difficulty of eating certain foods and liquids. SLP-A also stated she didn't do any cares with R13.	2 905		

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2 905	Continued From page 13 -10:55 a.m. NA-A exited room. -11:08 a.m. R13 was in the same position. -11:18 a.m. R13 put on the call light, NA-A entered room, asked "How can I help you?" and then stated "Oh, you want some more water." -11:19 a.m. NA-A exited the room. -11:21 a.m. NA-A entered the room with a glass of water. -11:24 a.m. NA exited the room and stated she brought the resident some water and had to thicken it. R13 was in the same position. -11:54 a.m. R13 was in the same position. -12:04 p.m. NA-A entered room with R13's lunch tray, set it up for him, and exited at 12:05 p.m. -12:07 p.m. NA-A R13 was in the same position except the HOB was elevated to a sitting position. -12:17 p.m. same position, no staff have entered the room. -12:28 p.m. NA-A removed R13's meal tray from his room, R13 was in the same position. -12:50 p.m. R13 was in the same position, no staff have entered the room. -1:01 p.m. NA-A stated the last time R13 was repositioned was "about an hour or two ago" then she stated "Well actually I put the head of his bead back down about a half hour ago and asked him if he was comfortable, but the last time I actually turned him on his side was about two hours ago." During interview on 6/20/24 at 11:26 a.m., NA-A stated the NA's complete rounds every 2 hours which included checking/changing briefs and re-positioning, also as needed. NA-A further stated if a resident refused to have their brief changed or to re-position they try to reapproach them later and if they still refuse, they should let the nurse know and document it. During a follow up interview on 6/20/24 at 1:01	2 905		

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2 905	Continued From page 14 p.m., NA-A stated the last time R13 was repositioned was "about an hour or two ago" then she stated "Well actually I put the head of his bead back down about a half hour ago and asked him if he was comfortable, but the last time I actually turned him on his side was about two hours ago." During interview on 6/20/24 at 7:25 a.m. LPN-B stated nurses were responsible for completing skin assessments twice a week on bath days. If they observe a new skin concern they are required to fill out a skin check form, if there are no new skin concerns they can just check it off on the treatment administration record (TAR) that it was completed. When a resident was admitted to the facility the receiving nurse was responsible for documenting if a resident was at risk for or had any skin alterations and then the nurse manager was responsible for adding interventions. It was the nurse managers responsiblity to follow up and make sure it was care planned. LPN-B further stated NA's were responsible for completing rounds every 2-3 hours which included checking/changing briefs, repositioning, and seeing if the resident needed anything. Repositioning would be considered to be when a resident was laying on their back and then would be repositioned on their side or using pillows to relieve pressure on one area of the body. Raising/lowering the HOB by itself would not be considered repsotioning a resident. NA's should report refusals by resident to reposition and the nurses should document it. During interview on 6/20/24 at 7:38 a.m., NA-E stated NA's should complete rounds every 2-3 hours and included checking/changing brieds and repositioning. NA's generally reposition residents from side to side, or onto their back if they are on	2 905		

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2 905	Continued From page 15 their side and raising/lowering the HOB would not be considered repositioning a resident. During interview on 6/20/24 at 8:20 a.m., the nurse manager registered nurse (RN)-A stated nurses and managers were expected to put in interventions on the admission assessment depending on what the receiving nurse triggered and she would expect skin interventions to be added right away upon admission, if the resident was at risk for skin breakdown. RN-A further stated re-positioning a resident would be considered side to side, onto their back, or raising the HOB and the feet, not just raising the HOB by itself. Also, asking a resident if they are comfortable dosen't mean they shouldn't be offered to be reprositioned. we want to prevent those skin breakdown. Usually in a TCU the residents need help to do those things and staff should encourage them. We want to prevent skin breakdown. RN-A also verified R13 didn't have any skin interventions added upon admission (before 5/29/24 when a pressure ulcer was noted on his heel). During interview 6/20/24 at 8:40 a.m., the director of nursing (DON) stated nurses were responsible for completing skin checks once a week on bath day and documenting it in the medical record. THe DON further stated interventions should be added right away on admission when a resident was at risk for skin breakdown. The DON would not consider raising/lowering the HOB of a resident to be repositioning. The facility's policy on the management of skin alterations dated 5/24/24, indicated on admission, readmission, quarterly, and significant change in condition, each resident will have a skin risk assessmentt and Braden assessment for	2 905		

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2 905	Continued From page 16 determination of risk. Appropriate interventions will be implemented based on assessment and will be placed on resident care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates	2 910		7/30/24

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2 910	Continued From page 17 that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a Foley catheter was removed according to physician orders for 1 of 1 resident (R4) who was admitted to the facility with an indwelling Foley catheter. Findings include: R4's admission Minimum Data Set (MDS) dated 5/20/24, indicated intact cognition, was dependent on staff for toileting hygiene, toileting transfers, had an indwelling catheter. R4's Medical Diagnoses form indicated the following: unspecified fracture of the lower end of the left femur (thigh bone), periprosthetic fracture (fracture around a joint replacement prostheses) around unspecified internal prosthetic joint, and retention of urine. R4's hospital encounter summary dated 5/14/24, indicated R4 had postoperative urinary retention and a history of urinary incontinence and failed a voiding trial on 5/9/24, and a catheter was replaced on 5/10/24. Further, the hospital discharge orders indicated a trial of voiding at the transitional care unit (TCU) in 5 days, and if R4 failed, could consider a urology evaluation as an outpatient.	2 910	corrected	

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2 910	Continued From page 18 R4's Care Area Assessment (CAA) dated 5/14/24, indicated R4 had a diagnosis of urinary retention and admitted with a Foley catheter and all catheter cares were by nursing. Additionally, the CAA indicated there was no order for a voiding trial and R4 was assisted with the bedpan for bowel movements upon request. R4's Physician Orders form indicated the following orders 5/19/24, monitor/record/report to the medical doctor signs and symptoms of a urinary tract infection, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Make sure output is recorded in point of care. 5/19/24, catheter care every shift. Document on characteristics of urine and output, make sure the urine bag is hanging below the level of your waist and check for kinks. 6/10/24, Change catheter and overnight bag every month and as needed unless otherwise directed. R4's Physician Orders form was reviewed and lacked the order for a trial of voiding at the transitional care unit (TCU) in 5 days and if R4 failed, can consider a urology evaluation as an outpatient. R4's medication administration record (MAR) and treatment administration record (TAR) was reviewed for May 2024, and June 2024, and lacked information a voiding trial was completed. R4's care plan dated 5/23/24, and revised on	2 910		

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2 910	Continued From page 19 6/6/24, indicated R4 had an indwelling catheter for a diagnosis of urinary retention and the goal was to remain free from catheter related trauma through the review date. Interventions indicated R4 required catheter care every shift and as needed, the catheter bag and tubing should be positioned below the level of the bladder and away from the entrance room door, the tubing should be checked for kinks, monitor intake and output as per facility policy, monitor for signs and symptoms of discomfort on urination and frequency, monitor, record, report to medical doctor signs and symptoms of a urinary tract infection, and observe and document pain and discomfort due to the catheter. R4's care sheet indicated R4 was incontinent of bowel and bladder. During interview and observation on 6/17/24, at 2:09 p.m., R4 had a Foley catheter and stated she had the catheter because she could not get up to go to the bathroom and had the catheter since she was in the hospital. During interview on 6/18/24 at 1:19 p.m., licensed practical nurse (LPN)-A stated she was not aware of any trial for removing R4's catheter and stated R4 had been at the facility a few times and could not recall R4 having a catheter on previous admissions to the facility and stated she would have to look in R4's chart to see why R4 had a catheter. During interview on 6/18/24 between 1:50 p.m., and 2:09 p.m. registered nurse (RN)-A stated if a resident had a catheter, they discussed with the provider and voiding trials were documented in the orders and they documented a bladder scan and how much resident was going and how much	2 910		

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2 910	Continued From page 20 residual was documented in the treatment administration record (TAR). RN-A stated admission orders were located in the document tab and verified in the orders that R4 was to have a voiding trial with in 5 days of admission and stated she did not think R4 had a trial and would have expected R4 to have a trial. RN-A further stated the admission orders were supposed to be located in the computer and in the resident's hard chart. RN-A viewed R4's medication administration record (MAR) and TAR and verified there was no documentation of a voiding trial. RN-A further viewed R4's progress notes and verified there was no documentation a voiding trial was completed. RN-A stated it was important to complete a voiding trial because of the risk of infection and stated the longer a catheter was in, the longer it took to recover and stated she did not know how the order was missed and stated generally they had a health unit coordinator (HUC) and another nurse check the orders. At 2:09 p.m., RN-A viewed the hard chart and verified the order for the trial of voiding and stated the order had been missed. During interview on 6/18/24 at 2:48 p.m., NA-D stated R4 was alert and oriented and able to report reliable information. During interview on 6/20/24 at 8:40 a.m., R4 stated she just had the catheter removed. During interview on 6/20/24 at 9:29 a.m., the director of nursing, (DON) stated orders were placed in the electronic medical record (EMR) for catheter cares. During interview on 6/20/24 at 9:31 a.m., RN-B stated they completed a comprehensive bowel and bladder assessment and look for the reason	2 910		

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2 910	Continued From page 21 for the catheter and then document in the EMR. During interview on 6/20/24 at 9:32 a.m., DON stated there may be an order on admission to remove a catheter and they would ask the nurse practitioner about a voiding trial and if a resident failed a voiding trial, they referred out. DON further stated if a resident had a voiding trial he expected the trial to be documented and stated R4 did not have parameters for the voiding trial and expected the nurse practitioner to provide parameters and further expected staff to clarify the orders and expected staff to document if they sought clarification. DON stated it was important to complete a voiding trial to make sure a resident was not retaining urine. A policy, Catheter Care, dated 9/2023, indicated it was the policy of the facility to provide care to the individual who must use an indwelling catheter with care that meets the necessary standards of infection control and dignity. An indwelling catheter will only be used after all other alternatives have been explored to minimize the risk of infection and GU (genitourinary) trauma. The catheter will be removed as soon as possible after the risks and benefits have been evaluated. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders to assure completion of ordered referrals are completed to prevent ordered referrals are provided. The director of nursing or designee, could conduct random audits of physician orders to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		

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21015	Continued From page 22	21015		
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: The facility failed to ensure dishware was cleaned and sanitized in a manner to reduce the risk of foodborne illness. This had potential to affect all 42 residents. Findings include: During observation and interview on 6/17/24 at 6:36 p.m., dietary (DA)-A loaded silverware, forks, and spoons in the dish washer. The dish washer temperature was 142 for wash cycle and 188 for rinse. Trays went through the washer, and the wash temperature was 142 and rinse temperature was 188. Plates went through the washer, and the washer temperature was 140 and the rinse temperature was 190. Items washed were being placed or stacked for later use. DA-B and DA-A referred to director of culinary (CD) and dining room coordinator (DRC) when asked about the dish washer temperatures. During subsequent observation and interview, CD stated the dish machine was a heat machine and a chemical rep comes out once a month. Dish detergent and dish rinse aid were observed to be attached to the dish machine. DRC stated they regularly put silverware, glasses, and other items through the dish washer multiple times as a	21015	corrected	7/30/24

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21015	Continued From page 23 standard practice. DA-B was stacking dishes and placing away from clean area of dish washer, and DRC directed DA-B to bring silverware to be washed through the dish machine again. CD reviewed the temperature log where dish washer temperatures were recorded, and the log indicated for the wash temperature to be 150 to 165 and the rinse temperature to be at least 180. The log directed staff to notify supervisor and/or maintenance immediately if temps not as specified. The log indicated wash temperatures between 140 to 174 and rinse temperatures between 165 to 192, and the dish washer temperatures for dinner had not been recorded yet. CD stated the timing of checking the dish washer temperatures surrounding meals varied but usually was done prior to washing dishes to ensure the dish washer was running correctly. More dishes ran through the dish washer, and DRC verified the wash temperature at 142 and rinse at 190. DRC pointed to a stick on the front of the machine which indicated 140 was the low temperature and 150 the high temperature. DRC pointed to different setting which may be used to wash heavier More dishes were washed, and CD verified wash temperature of 144 and rinse temperature of 190. CD expected staff to tell them when the dish machine was not getting to the correct temperatures, and then CD contacted maintenance who fixed immediately. DRC stated if they could not use the dish washer, they used plasticware until fixed again. During observation on 6/18/24 at 10:06 a.m., the dish machine had a manufacturer sticker which identified the minimum wash temperature as 150 and the minimum rinse temperature as 180. During interview on 6/20/24 at 12:39 p.m., DA-C stated they checked dish washer temperatures	21015		

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	31815	A. BUILDING: _____ B. WING _____	06/20/2024

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21015	Continued From page 24 after breakfast, lunch, and dinner meal. DA-C stated the wash temperature either needed to be 140 or 150 and higher and 180 for the final rinse temperature. DA-C stated they would let senior chef or CD know if the dish washer was not getting up to appropriate temperature. During follow up interview on 6/20/24 at 1:38 p.m., CD verified the dish machine in the transitional care unit kitchen was a high temperature dish washer and stated they wanted to provide safe food service and did not want residents to get sick from the food service. The facility provided Jackson TempStar manual dated 8/31/23, directed operators to refer to the machine data plate for specific water requirements. The facility policy "Cleaning Dishes with Dish Machine" dated 2/19, indicated the wash temperature must reach temperatures between 140 to 160 degrees and rinse temperature must reach 180 degrees or higher. The policy and procedure directed staff to monitor temperatures throughout the dish washing process and record one set of temperature for each meal service. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance.	21015		

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21015	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening for history, risk factors, and symptoms were completed for 2 of 5 residents (R3, R16). Findings include:	21426	corrected	7/30/24

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21426	Continued From page 26 R3's admission Minimum Data Set (MDS) dated 5/2/24, indicated R3 was cognitively intact and had diagnoses of heart failure, pneumonia, renal disease, and fracture. R3's TB screen under Admission/Readmission assessment dated 4/26/24, indicated R3 did not have symptoms of active TB disease and the rest of the questions about history and risk factors of TB were left blank. R16's admission MDS dated 5/16/24, indicated R16 was cognitively intact and had diagnoses of cancer, hypertension, diabetes mellitus, thyroid disorder, arthritis, and fracture. R16's TB screen under Admission/Readmission assessment dated 5/10/24, indicated R16 had not had an adverse reaction or positive reaction to a TB test, was not born outside the United States, and had not traveled or lived outside of the US in the past two years, and did not have current symptoms of TB. 14 other questions were unanswered. During interview on 6/20/24 at 10:15 a.m., registered nurse (RN)-C stated nurses completed resident Mantoux tests or ensured chest x-ray completed and was unsure who completed the admission TB screening which included signs and/or symptoms of TB. During interview on 6/20/24 at 10:15 a.m., licensed practical nurse (LPN)-B stated nurses completed an assessment upon admission which asked about residents' history, risk factors, and signs and/or symptoms of tuberculosis. During interview on 6/20/24 at 2:11 p.m., infection preventionist (IP) stated residents were screened upon admission for tuberculosis by the nurses,	21426		

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21426	Continued From page 27 and the nurse managers reviewed the admission assessments to make sure everything was completed. IP confirmed R3's tuberculosis assessment was blank besides none was selected for symptoms of active tuberculosis, and R16's tuberculosis assessment was less than halfway completed. IP stated it was important to assess the residents prior to testing for tuberculosis. The facility policy and procedure "Tuberculosis Screening- Resident" dated 11/1/23, indicated all residents would be assessed for symptoms of and risk factors for tuberculosis upon admission. Factors which precluded the 2-step TST (tuberculin skin test) or QuantiFERON TB-Gold blood test were history of positive TST or QuantiFERON TB-Gold blood test and negative chest x-ray dated after the positive TST, and admitted from another qualified hospital or nursing facility with documentation of TST administered at that facility within the last 3 months. If one TST was completed at the other facility, administer only one TST.	21426		