Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 14, 2023

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

RE: CCN: 245637
Cycle Start Date: November 3, 2023

Dear Administrator:

On November 3, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 29, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 29, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 29, 2023.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 29, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Norris Square will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 29, 2023. 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, Unit Supervisor
Metro B District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: 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 Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 3, 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://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/30/23-11/03/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/30/23-11/03/23, 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: H56376703C (MN00092793) H56377308C (MN00089909) H56376942C (MN00098149) The following complaints were reviewed: H56376790C (MN00096470) and H56376886C (MN00098170) with a deficiency cited at F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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

Electronically Signed | 11/22/2023

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

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F 000	Continued From page 1 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 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585		11/28/23

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F 585	Continued From page 2 (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a	F 585		

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F 585	Continued From page 3 summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their grievance process to ensure a voiced grievance concerning activities was resolved to satisfaction for 1 of 2 residents (R29) reviewed for grievances. Findings include: R29's significant change Minimum Data Set (MDS) dated 3/2/23, indicated it was very important R29's family or close friend was involved in discussions about care, was very important to have books, newspapers, and magazines to read, listen to music, do things with groups of people, do favorite activities, and participate in religious services or practices.	F 585	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.	

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F 585	Continued From page 4 R29's quarterly MDS dated 9/1/23, indicated R29 had a memory problem, was dependent on staff for most activities of daily living (ADLs), had minimal difficulty hearing and wore a hearing aid. R29's Medical Diagnosis form (undated), indicated the following diagnoses: unspecified severe dementia with other behavioral disturbance, delusional disorders, major depressive disorder, and difficulty in walking. R29's care plan dated 9/25/23, indicated R29 was dependent on staff for activities due to dementia and would attend activities of choice. An intervention dated 10/31/23, indicated R29 had an electric keyboard to use at the table. Other interventions included R29 required one to one visits if R29 was unable to attend group activities, assistance to attend activity functions, invite to scheduled activities including church, special music, bingo, exercise, socials, outdoor activities, and coloring, take to any and all religious services and take to communion, when R29 chose not to participate in organized activities to provide independent activities in common areas to include cards, and activity blankets. R29's Quality Concern form dated 10/18/23, completed by house hold coordinator (HHC)-C indicated family member (FM)-B was concerned the common area television was not set to a TV program channel, but was set to music and wanted more at R29's table to keep busy. Additionally, HHC-C contacted R29's family to provide ideas on items to keep R29 busy and followed up with staff by posting a small reminder sign on the TV for the appropriate volume level and generation appropriate shows to enjoy. Under section four of the form, the administrator	F 585	R29 was comprehensively reassessed for activity preferences and preferences care plan updated to reflect preference.¿A facility audit will be completed on all residents for activity preferences and preferences care planned per policy.¿HHC and Administrator reeducated on the Grievance policy.¿¿¿ HHC will audit all current Grievances to ensure they comply with the addressed minimally within five working days and communicated procedure and that all paperwork is completed and complies with the Grievance Policy as stated in the Quality Concern/Grievance Process.¿¿ ¿¿ The administrator will present, and review newly submitted grievances weekly during scheduled IDT meetings to ensure the grievance policy is being followed.¿ An audit conducted by the HHC will be completed on a weekly basis for all new Grievances for four weeks and then every two weeks for 6 months verifying that the Grievances Procedure is followed and addressed minimally within five working days and communicated to the individual submitting the grievance.¿¿¿ ¿¿¿ The correction will be monitored by:¿¿ 1. Household Coordinator and Administrator will present and review each appropriate Grievance at scheduled IDT	

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F 585	Continued From page 5 spoke with life enrichment about giving R29 more options on 10/19/23, however the form was undocumented under the sections, "Person that completed this form contacted and updated on this date" along with "Name of person making the follow up contact." During observation 10/30/23 at 6:01 p.m., R29 was in her room in bed. During observation on 10/31/23 at 9:39 a.m., R29 was out in a day room with the television on and had a stuffed cat next to her. During interview on 10/31/23 at 10:11 a.m., FM-B stated R29 had no social interaction and added R29 used to be a director of a program and went to nursing facilities every day to entertain residents and was now spending her life alone. FM-B further stated R29 was an extremely social person. FM-B stated staff turned on the music channel, but stated it was so quiet, FM-B could not hear the television. FM-B stated they have expressed concerns for the past couple of years, and the answer they received was they were working on it, but nothing ever changed. During observation on 10/31/23 at 1:40 p.m., R29 was in bed and the door to the room had been closed and R29's shades were drawn and the room was dark. R29 had mouth movements. During interview on 10/31/23 at 1:48 p.m., nursing assistant (NA)-A stated R29 required total assist for cares and staff lay R29 down after lunch. During interview and observation on 10/31/23 at 2:20 p.m., R29 was brought out to the day room	F 585	meetings and audits will be completed by HHC and reviewed by the Administrator for a term of four weeks and then every two weeks for 6 months.¿¿ 2. Administrator will report audits to the QAPI Committee.¿ QAPI will determine frequency and need for audits after the 6-month period.¿¿¿ 3. The Administrator will be responsible for compliance¿¿ 4. Date of compliance 11/28/2023¿¿	

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F 585	Continued From page 6	F 585		

and was given a key board, activity coordinator (AC)-A turned on a black and white movie and left resident by herself. AC-A stated they documented who attended activities.

During interview on 11/2/23 at 9:09 a.m., registered nurse (RN)-A stated R29 had severe dementia and could not effectively communicate her needs to staff. When R29 saw staff she called for their attention and most of the time wanted to hold your hand and stated staff should pay attention and talk with R29 and offer a keyboard. RN-A stated R29 wanted to be involved in activities and exercises, especially music.

During interview on 11/2/23 at 12:22 p.m., administrator (A)-D stated he documented responses such as following up with culinary on the Quality Concern form and stated he hoped to follow up with the resident or family to see if they were satisfied.

During interview on 11/2/23 at 3:28 p.m., A-D stated he expected grievances to be taken care of immediately because he did not want someone to get the courage to submit a grievance and then not hear about if for a couple of days.

A policy, Quality Concern/Grievance Process undated, indicated if the concern or grievance was being filed orally, the staff member receiving the information should write a brief description of the concern, if the staff member receiving the concern can immediately address the issue this will be noted in section three and the form will be signed and dated with a copy routed to the administrator. The concern or grievance will be addressed minimally within five working days and action items will be communicated to the

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F 585	Continued From page 7 individual filing the grievance unless indicated as anonymous.	F 585		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 604	R 29, pillow was immediately removed	11/28/23

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NORRIS SQUARE	6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016

(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 604	Continued From page 8 review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R29). Findings include: R29's quarterly Minimum Data Set (MDS) dated 9/1/23, indicated R29 was dependent on all activities of daily living (ADLs), incontinent of bowel and bladder, had fallen, and did not use restraints. R29's Medical Diagnosis form (undated), indicated the following diagnoses: unspecified dementia, severe, with behavioral disturbance, delusional disorders, senile degeneration of the brain, disorientation, muscle weakness, and difficulty in walking. R29's clinical physician orders were reviewed and lacked orders for a restraint. R29's care plan dated 2/23/23, indicated R29 required one person assist to reposition and turn in bed. Additionally, R29 was at high risk for falling and should not lie down if she was not sleeping. R29's care plan dated 9/13/23, indicated R29 was at risk for falls due to a history of falling and had a perimeter mattress on the bed. During observation on 10/30/23 at 6:01 p.m., R29 was in bed lying on a perimeter mattress and resident had a pillow located on the outer right side of the bed and was not under R29. During observation on 10/31/23 at 1:40 p.m., R29 was in bed and had pillows located under R29's	F 604	from resident. Staff were educated at the time of incident that this is considered a restraint. Resident care sheet was updated to say, do not put pillows under fitted sheet when in bed. Dated 10/30/23.¿¿ A facility audit was completed to ensure there were no other restraints in place.¿¿ The Restraint Policy was reviewed, no changes were made.¿¿ All nursing staff will be re-educated regarding the Restraint policy.¿¿¿ Weekly at random audits of 10% of residents will be completed x 4 weeks and then monthly with a compliance goal of 100%. Clinical Coordinator or designee will conduct audits and DON, or designee will be responsible for oversight of compliance. The Care Center Administrator will present the results at QAPI (Quality Assessment and Performance Improvement).¿¿Date Certain 11/28/2023	

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F 604	Continued From page 9 fitted bed sheet on the side of the bed facing R29's door. During interview and observation on 10/31/23 at 1:48 p.m., nursing assistant (NA)-A stated R29 required complete assistance with cares and was at risk for falling. NA-A stated in order to prevent falls, the bed is placed in the lower position and pillows were placed under the bed sheet to prevent R29 from jumping out of bed. During interview and observation on 10/31/23 at 2:04 p.m., registered nurse (RN)-A stated R29 should not have pillows under the bed sheet because it was a form of a restraint and removed the pillows and further stated R29 has tried to get out of bed in the past. During interview on 11/2/23 at 1:37 p.m., the director of nursing (DON) stated residents cannot be restrained. A policy, Physical Restraint Policy dated November 2022, indicated the facility had a stringent policy regarding the use of physical and chemical restraints. A physical restraint is defined as any manual method, physical or mechanical device, equipment or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to their body.	F 604		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		11/28/23

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F 677	Continued From page 10 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grooming was offered and/or provided for 1 of 1 resident (R31) reviewed for shaving. Findings include: R31's quarterly Minimum Data Set (MDS) dated 9/1/23, indicated intact cognition, rejected cares four to six days, had moderate difficulty in hearing, required extensive assistance for bed mobility, transfers, ambulation in the room, dressing, toileting, and hygiene, and was frequently incontinent of bowel and bladder. R31's Admission Record form dated 11/2/23, indicated R31 had the following diagnoses: anxiety disorder, unspecified dementia, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, and senile degeneration of the brain. R31's care plan dated 3/9/23, indicated R31 had an activities of daily living (ADL) deficit related to depression, anxiety, and mild dementia and refused baths and was resistive with cares at times and required assist of one with dressing, grooming, and hygiene. Additionally R31 required an explanation of the reasoning for the care to be done as needed, what cares would be done prior to starting cares, and if R31 refused, was to be reapproached. Additionally, if R31 refused care or bathing, to report to the nurse. R31's nursing progress notes were reviewed 3/9/23 through 11/2/23, and on 3/18/23, had	F 677	R31 was assisted with facial hair removal. The care plan and care guide were reviewed to ensure resident preference.¿¿Facility audit of all resident preferences for removal of facial hair was completed and care planned preference indicated on care plan. ¿¿ Resident care policy was reviewed, and no updates were made.¿¿ Staff will be educated on the Resident Care Policy regarding daily hygiene care. ¿¿ ¿Facial hair audits will be completed by Clinical Coordinator or designee on 10% of residents per week x 4 and then monthly until a 90% or greater compliance goal is achieved.¿ DON or designee will be responsible for audit oversight and presenting results to QAPI.¿¿Date Certain 11/28/2023	

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F 677	Continued From page 11 refused brief change despite explanation and a progress note dated 3/14/23, indicated R31 refused baths at times, was hard of hearing, used a pocket talker to communicate and staff were to use the pocket talker to help R31 communicate. Additionally on 9/15/23, R31 was incontinent of bowels and had initially refused to be changed, however allowed the staff to change after staff provided an explanation. R31's Weekly Body Audit form dated 10/19/23 and 10/26/23, indicated R31 received a shower. R31's care sheet dated 10/11/23, indicated R31 had a bath on Thursdays, could be resistive with cares, and would refuse baths at times, staff should avoid yes or no questions related to cares and showers but instead state it was time to do a certain task, and explain the task. The care sheet lacked information regarding providing shaving assistance. R31's Task Personal Hygiene form from 10/4/23 through 11/2/23, indicated how R31 maintained personal hygiene such as combing hair, brushing teeth, shaving, applying makeup, and washing and drying face and hands. The form indicated R31 refused the task four times on 10/14/23, 10/24/23, 10/25/23, and 10/29/23. The form identified, R31 required extensive assistance 29 times, limited assistance 16 times, supervision twice, and was independent three times on 10/13/23, 10/20/23, and 11/2/23. R31's Task Bathing form from10/3/23 through 10/31/23, indicated R31 did not refuse bathing. During observation on 10/30/23 at 2:03 p.m., R31 had hairs approximately one half an inch long on	F 677		

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F 677	Continued From page 12 her chin. During observation 10/31/23 at 9:27 a.m., R31 was in her room and still had a thick patch of hairs on R31's chin. During observation on 11/1/23 at 8:50 a.m., nursing assistant (NA)-A assisted R31 in a.m., cares that included assisting in washing R31's face, under arms, peri cares, combing hair, doffing night clothing and dressing R31. NA-A did not offer to shave or provide any explanation on shaving R31. During interview on 11/1/23 at 9:07 a.m., R31 stated NA-A did not offer to shave R31's chin hairs and stated this would have been something she wanted done. During interview on 11/1/23 at 1:44 p.m., R31 stated she did not receive assistance with shaving and still had the long chin hairs. During interview on 11/1/23 at 1:44 p.m., NA-A stated they looked at the care sheet to know what cares a resident required, refusals were documented in the nurse aide documentation, R31 did not refuse any cares today and further stated if R31 refused cares, staff had to reapproach and then R31 would usually agree to cares. NA-A stated personal hygiene included washing hair, face, and shaving and stated R31 did not get shaved because she did not have any chin hairs and if R31 did have chin hairs, NA-A would have to check the care plan. NA-A verified shaving hygiene was not on the care sheet and later stated, he thought he had seen the chin hairs and was not sure how long they had been there, but there was nothing on the care sheet to	F 677		

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F 677	Continued From page 13 indicate they needed to shave R31. During interview on 11/1/23 at 1:56 p.m., registered nurse (RN)-B stated the NA's had care sheets to know what kind of cares a resident required and stated personal hygiene consisted of brushing teeth, combing hair, washing face, and shaving. RN-B stated she had seen the chin hairs and staff should ask if R31 wanted to shave. RN-B further stated R31's chin hairs have been like that since mid September and expected female residents to not have chin hairs. During interview on 11/2/23 at 1:34 p.m., the director of nursing (DON) stated she expected cares to be completed as care planned. A policy, Bath, Partial dated December 2014, indicated the purpose was to clean, refresh, and sooth the resident, but lacked information on shaving the resident. A policy, Shaving the Resident dated December 2014, indicated the purpose was to remove facial hair and improve the resident's appearance and morale. The policy provided instruction on how shaving was to be completed, but lacked information regarding when shaving was to be completed.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and	F 679		11/28/23

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F 679	Continued From page 14 individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to provide meaningful activities for 1 of 2 residents (R29) who was dependent on staff for activities. Findings include: R29's significant change Minimum Data Set (MDS) dated 3/2/23, indicated it was very important R29's family or close friend was involved in discussions about care, was very important to have books, newspapers, and magazines to read, listen to music, do things with groups of people, do favorite activities, and participate in religious services or practices. R29's quarterly MDS dated 9/1/23, indicated R29 had a memory problem, was dependent on staff for most activities of daily living (ADLs), had minimal difficulty hearing and wore a hearing aid, and did not reject care. R29's Medical Diagnosis form (undated), indicated the following diagnoses: unspecified severe dementia with other behavioral disturbance, delusional disorders, major depressive disorder, and difficulty in walking. R29's care plan dated 9/25/23, indicated R29 was dependent on staff for activities due to dementia and would attend activities of choice. An intervention dated 10/31/23, indicated R29 had an	F 679	Life Enrichment staff reviewed resident R-29□s care plan and immediately increased 1:1 activity and provided materials of preferences during the visits.¿¿ Life Enrichment and Household Coordinator staff were re-educated on the requirement for meeting the individual activity needs of each resident.¿¿ ¿ Administrator reviewed the MDS (Minimum Data Set) Life Enrichment assessment Policy and procedure. The IDT team will review resident preferences at weekly meetings to ensure individualized activity preferences and barriers to preferences are provided and resolved, respectively. 10% of Life Enrichment assessments will be audited daily by HHC for four weeks to ensure resident preferences are followed with a compliance goal of 90% or greater.¿ Results of the Audits will be reviewed weekly at scheduled IDT meetings which includes Life Enrichment staff, Nursing, Household Coordinator, and Administrator.¿ Administrator and Life Enrichment staff will monitor and review audits for trends or concerns.¿¿¿	

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F 679	Continued From page 15 electric keyboard to use at the table. Other interventions included R29 required one to one visits if R29 was unable to attend group activities, assistance to attend activity functions, invite to scheduled activities including church, special music, bingo, exercise, socials, outdoor activities, and coloring, take to any and all religious services and take to communion. When R29 chose not to participate in organized activities to provide independent activities in common areas to include cards, and activity blankets. R29's Task Activity Participation form dated 10/4/23 through 11/2/23, indicated R29 did not refuse activities, was unavailable for activities 16 times after 1:00 p.m., including Wednesdays on 10/4/23, 10/11/23, 10/18/23, 10/25/23, and11/1/23. R29's Task Event dated 10/4/23 through 11/2/23, indicated R29 attended the following activities: Bingo one time Campus wide activity one time Exercise 25 times Games one time Guest or family visit two times Music 5 times Chaplain visit zero times Had zero 1:1 visits R29's activity calendar dated October 2023 and November 2023, indicated the following activities were offered during the time frame 10/4/23 through 11/2/23: Bingo was an activity 7 times Exercise 36 times Catholic Mass at 11:00 a.m., on Wednesdays 5 times, Chapel Service at 2:00 p.m., on Wednesdays 5 times, and, rosary at 11:00 a.m.,	F 679	The correction will be monitored by:¿ 1. All Life Enrichment audits will be reviewed by the Administrator.¿ 2. Administrator will report audits to the QAPI Committee for trends.¿¿ 3. The Administrator will be responsible for compliance.¿ 4. Date of compliance 11/28/2023¿	

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F 679	Continued From page 16 on Thursdays 5 times Music 8 times R29's Quality Concern form dated 10/18/23, completed by house hold coordinator (HHC)-C indicated family member (FM)-B was concerned the common area television was not set to a TV program channel, but was set to music and wanted more at R29's table to keep busy. Additionally, HHC-C contacted R29's family to provide ideas on items to keep R29 busy and followed up with staff posting a small reminder sign on the TV for the appropriate volume level and generation appropriate shows to enjoy. Under section four of the form, the administrator spoke with life enrichment about giving R29 more options on 10/19/23, however the form was undocumented under the sections, "Person that completed this form contacted and updated on this date" along with "Name of person making the follow up contact." During observation 10/30/23 at 6:01 p.m., R29 was in her room in bed. During observation on 10/31/23 at 9:39 a.m., R29 was out in a day room with the television on and had a stuffed cat next to her. During interview on 10/31/23 at 10:11 a.m., FM-B stated R29 had no social interaction and added R29 used to be a director of a program and went to nursing facilities every day to entertain residents and was now spending her life alone. FM-B further stated R29 was an extremely social person. FM-B stated staff turned on the music channel, but stated it was so quiet, FM-B could not hear the television. FM-B stated they have expressed concerns for the past couple of years,	F 679		

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F 679	Continued From page 17 and the answer received was they were working on it, but nothing ever changed. During observation on 10/31/23 at 1:40 p.m., R29 was in bed and the door to the room had been closed. R29's shades were drawn and the room was dark. R29 had mouth movements. During interview on 10/31/23 at 1:48 p.m., nursing assistant (NA)-A stated R29 required total assist for cares and staff lay R29 down after lunch. During interview and observation on 10/31/23 at 2:20 p.m., R29 was brought out to the day room and was given a key board, activity coordinator (AC)-A turned on a black and white movie and left resident by herself. AC-A stated they documented who attended activities. During observation 11/1/23 at 6:57 a.m., R29 was in the day room and playing the keyboard with the television off. During observation on 11/1/23 at 9:24 a.m., R29 was in the day room and the TV was turned on. An activity calendar for 11/1/23, indicated catholic mass was at 11:00 a.m., chapel services were at 2:00 p.m., short stories started at 10:30 a.m., and morning exercises began at 10:00 a.m. During interview on 11/2/23 at 9:09 a.m., registered nurse (RN)-A stated R29 had severe dementia and could not effectively communicate her needs to staff, stated when R29 saw staff she called for their attention and most of the time wanted to hold your hand, staff should pay attention and talk with R29 and offer a keyboard. RN-A stated R29 wanted to be involved in	F 679		

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F 679	Continued From page 18 activities and exercises, especially music. RN-A stated staff had care sheets or a care plan that summarized the care a resident required. During interview on 11/2/23 at 9:42 a.m., the life enrichment specialist (LES)-B stated she completed an MDS assessment about preferences, resident's attendance was tracked and reported at resident care conferences. LES-B stated she could go back months to review attendance. LES-B stated R29 attended music one time in the past 30 days, and added R29 hasn't attended church services because they were in the afternoon. LES-B further stated R29 did not receive one to one visits from the chaplain, but was something they could set up. Additionally, from 10/4/23 to 11/1/23, LES-B stated R29 attended bingo only once because that was held in the afternoon. LES further stated R29 went to church twice in the past month and church services were held every week on Wednesdays. LES-B stated it was very important for R29 to attend church, very important to have books and magazines, listen to music, be in groups of people. LES-B stated expected there to be care planning for R29 to take a nap around the times of scheduled activities so R29 could attend. LES-B added they spoke with nursing about staff changing nap times however, it was difficult to find a balance. LES-B expected the chaplain to visit if R29 could not attend church. During interview on 11/2/23 at 1:37 p.m., the director of nursing (DON) stated the purpose of a preferences assessment was to create an individualized care plan and meet the needs of the resident and expected the assessment to reflect what R29 was capable of or what was appropriate for R29.	F 679		

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F 679	Continued From page 19 During interview on 11/2/23 at 4:32 p.m., LES-B stated after 1:00 p.m., activity participation indicated not available because R29 was put to bed in the afternoons. LES-B further stated, staff state, "oh shoot, we just put her to bed," when asked about activities. Additionally, despite the October calendar for activities on 10/18/23 and 10/25/23, indicated chaplain, LES-B stated the chaplain had a function work group and was not at the facility on 10/18/23 and 10/25/23. A policy, Care Plan Policy and Procedure dated November 2022, indicated the person centered care plan will ensure the resident has the appropriate care required to maintain or attain the resident's highest practicable physical, mental, and psychosocial well-being. The team will continue to collect additional information and data including but not limited to the registered nursing assistant, licensed nurse, life enrichment representative and will develop a comprehensive care plan that contains both strengths and vulnerabilities and dependencies. The care plan is to be changed and updated as the care changes for the resident and as the resident changes occur it will be updated in the electronic medical record. It is to be current at all times.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		11/28/23

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F 684	Continued From page 20 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure effective collaboration between the facility and a contracted hospice organization for 1 of 2 resident (R22) reviewed for hospice services. Findings include: See also F686 R22's Face Sheet form indicated the following diagnoses: unspecified protein calorie malnutrition, pressure ulcer of unspecified buttock stage three, major depressive disorder, and type two diabetes. R22's hospice election benefit indicated R22 enrolled in hospice on 10/4/23. R22's admission Minimum Data Set (MDS) dated 6/27/23, indicated intact cognition, did not reject care, required partial to moderate assistance with toileting, showering, was occasionally incontinent of bladder, was five feet tall and 105 pounds, was at risk of developing pressure ulcers and did not have one or more unhealed pressure ulcers at a stage one or higher. Under the section "Skin and Ulcer Treatments" R22 had a check mark next to applications of ointments and medications other than to feet. R22's significant change in status (MDS) dated 9/27/23, indicated R22 had moderate cognitive impairment, did not reject care, was occasionally incontinent of bladder, and frequently incontinent	F 684	A comprehensive review was completed on R22 to ensure hospice coordination is being provided per policy. R22 Care plan and care sheets were updated to note any changes (related to need for alternating cushion) in treatments. A comprehensive review was completed of all other hospice residents per established hospice policy and procedure. The Hospice Care Coordination policy has been reviewed and no changes made. All care center nurses will be reeducated on the Hospice Care coordination policy. The care coordination policy was sent on 11/22/2023 to the hospice nurses for them to review. The DON or designee will meet weekly with the hospice team to review hospice resident plans of care and care sheets to ensure consistency and collaboration weekly x 4 weeks for 10% of residents receiving hospice services. Collectively, the hospice designee and DON or designee will conduct a root cause analysis of any resident plans of care/services that are determined non-compliant during the weekly audit. Weekly audits resulting in less than 90% compliance will be reviewed by the DON or designee at the subsequent QAPI meeting where trends, patterns, and recommendations for audit continuation will be determined. Date Certain	

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F 684	Continued From page 21 of bowel, was 104 pounds, was at risk for pressure ulcers and had one stage three pressure ulcer and under the section, "Skin and Ulcer Treatments" had a check mark next to pressure relieving device for R22's chair and bed, had nutrition or hydration intervention to manage skin problems, pressure ulcer care, and applications of ointments and medications other than to feet. R22's significant change in status (MDS) dated 10/11/23, indicated moderate cognitive impairment, did not exhibit behaviors, and did not reject care. Required substantial maximal assistance for toileting hygiene, partial moderate assist for moving from sitting to lying, and chair to bed to chair, and toileting transfers required supervision or touching assistance, was occasionally incontinent of urine and always continent of bowels. R22's weight was 101 pounds, was at risk of developing pressure ulcers and had two stage three pressure ulcers, and under the section, "Skin and Ulcer Treatments" had a check mark next to pressure reducing device for chair, bed, pressure ulcer care, applications of ointments and medications other than to feet. R22's care plan dated 10/6/23, indicated R22 received hospice services. R22's care plan dated 7/7/23, indicated an activity in daily living (ADL) self care performance deficit and required staff assistance due to limited mobility, impaired balance and an intervention included to observe skin for redness, open areas, scratches, cuts, bruises and report changes. R22's care plan dated 7/7/23, indicated R22 had	F 684	11/28/2023.	

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F 684	Continued From page 22 limited physical mobility and required staff assistance due to limited mobility and impaired balance. The care plan was later updated on 11/2/23, to include an intervention identifying R22 required assist of one to reposition in bed and assist of two to boost up in bed. This intervention further indicated R22 had an air pressure reduction mattress on the bed, and R22 preferred to sleep in the recliner and had an air pressure cushion. Prior to 11/2/23, the bed mobility intervention was last revised on 9/13/23, to include R22 required assist of one to reposition self in bed and encourage off loading in bed and chair. R22's care plan dated 10/9/23, indicated an altered nutritional status due to weight loss and impaired skin integrity. Interventions indicated providing a diet as ordered, monitor intake, obtain weights, monitor lab work, honor food preferences and requests. R22's care plan dated 10/13/23, indicated R22 was at risk for impaired skin integrity due to limited mobility, medication side effects, bladder incontinence, malnutrition and had two stage three pressure ulcers on the left buttock and coccyx. R22's goal indicated the current pressure ulcers would show signs of improvement by the next review date as evidenced by a decrease in size or a resolved status. Interventions indicated following facility protocols and policies for prevention of skin breakdown, a pressure reducing mattress, able to request assistance for toileting and repositioning, observe for signs and symptoms of breakdown and update the nurse promptly if noted. The most recent intervention on the care plan was dated 8/4/23, and indicated R22 required a	F 684		

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F 684	Continued From page 23 pressure reducing wheelchair cushion. No new interventions were added following the development of new pressure ulcers. R22's care sheet dated 10/11/23, indicated R22 required assist of one with a transfer belt for transfers and ambulating short distances. Additionally, R22 required assist of one when going to the bathroom, and with dressing, grooming, and bathing and required a body audit completed on Thursdays, further, R22 required frequent repositioning and offloading while in the bed and wheelchair. The care sheet had a yellow highlighted instruction dated 8/4/23, to remind R22 to reposition off bottom for a few minutes every two to three hours due to having a pressure ulcer. The care sheet lacked any information or instruction resident had a cushion for the reclining chair. During interview and observation on 10/30/23 between 5:48 p.m., and 5:50 p.m., R22 stated she had irritation on her bottom that was hard to heal and stated they provided a pillow to use, and had not spoken with her about staying off her bottom. R22 had a circular cushion in another chair but did not have a cushion in the recliner R22 was in. R22 had a cushion in the wheel chair and additionally had an air mattress on her bed. R22's care sheet updated on 10/11/23, lacked interventions for a cushion in the recliner. During observation on 11/1/23 at 6:56 a.m., R22 was in her room in her reclining chair and her head was bent forward. During interview at 11/1/23 at 7:19 a.m., registered nurse (RN)-B stated R22 slept in her	F 684		

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F 684	Continued From page 24	F 684		

recliner 90% of the time and refused to sleep in the bed despite encouragement and added it was R22's choice. RN-B stated R22 was supposed to have a cushion in the chair she slept in.

During interview and observation on 11/1/23 at 7:25 a.m., R22 was in the bathroom with staff and had a circular type cushion in her arm chair, but was not in R22's recliner chair where she slept. Nursing assistant (NA)-B stated she had worked at the facility for two years and stated R22 slept in her recliner chair. NA-B verified the circular cushion was not in R22's recliner chair she slept in this morning when R22 got up and verified R22 did not have any type of cushion in her recliner when she assisted her to get up. NA-B stated they toileted and repositioned R22 and stated R22 was continent. NA-B offered to apply the circular cushion to R22's recliner chair and R22 accepted. NA-B stated as the day goes on, R22 got weaker and needed assist and stated R22 could shift positions in her chair and added they tried to push for R22 to sleep in the bed as much as possible.

During interview on 11/1/23 at 10:19 a.m., NA-C stated R22 could not get out of the recliner by herself and when R22 stood, she pushes off the chair, but cannot get up on her own and just rocks in her chair and needed assist.

During interview on 11/1/23 at 12:54 p.m., licensed practical nurse (LPN)-B stated wounds were measured once a week and stated R22 had two pressure ulcers and one was near the coccyx and the other on the left gluteal fold. LPN-B clarified R22's left buttocks was deteriorating and

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F 684	Continued From page 25 stated it looked like it was deeper and like the wound was not improving. LPN further stated the pressure ulcers were hard to heal because R22 did not get off her bottom and wasn't eating well. LPN-B stated R22 could get up to go to the bathroom by herself and added R22 slept in her recliner chair. During interview on 11/1/23 at 1:07 p.m., nurse manager (NM)-G stated she asked hospice about an offloading cushion for R22 at the care conference on 10/13/23, and added R22 received an air mattress for her bed, and a gel cushion for R22's wheel chair. NM-G verified the care conference note lacked information regarding a cushion for the recliner chair. NM-G further stated R22 wished to only sleep in her chair and when asked about a circular cushion observed in R22's room, NM-G stated the cushion could have come from hospice and hoped the family brought in the cushion because hospice should notify the facility if they bring items in. NM-G further stated she had not followed up to see if interventions were effective and did not follow up to verify if a cushion was in place. During interview on 11/1/23 at 1:14 p.m., LPN-B verified no wound assessments were completed after 8/4/23, until 8/25/23. LPN-B stated from 10/10/23, to 10/26/23, they were missing a week of assessments. LPN-B further stated the problem with putting the cushion in the chair when they had therapy look at it, was the manufacturer wouldn't approve a cushion in the recliner because they couldn't guarantee it wouldn't slide out and that was why they asked hospice to look into it.	F 684		

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F 684	Continued From page 26 During interview on 11/1/23 at 2:20 p.m., the health unit coordinator (HUC)-H verified the hospice notes in the paper chart and in the electronic medical record (EMR) lacked any information regarding a cushion or follow up on a cushion for the reclining chair. During interview and observation on 11/1/23 at 3:38 p.m., R22 was in her reclining chair with a pillow behind her back, but there was no cushion on the seat of the recliner chair. RN-F measured the wound on R22's left buttocks and was 1.6 cm long by 0.9 cm wide and 0.3 cm deep. RN-F measured the wound to R22's coccyx and was 1 cm long by 1 cm wide that included tunneling in the right inside corner that measured 0.4 cm at 1 O'clock. RN-F also stated R22 had a new stage one pressure injury to R22's right inner buttocks that measured 0.7 cm long by 0.9 cm wide. RN-F stated R22 did not want the cushion her daughter gave her and stated R22 didn't always use it and stated R22 was on a repositioning schedule and occupational therapy got R22 a special cushion she thought was the circular cushion. RN-F stated since R22 had a new wound they may have to do something different and verified that wound assessments were supposed to be done weekly and used to be completed on Wednesdays, but stated there had been some changes and verified wound assessments were documented in the chart and were missed. RN-F further stated if wounds are not monitored they are going to get worse because you cannot evaluate a wound if you are not assessing them and expected there to be interventions in place regarding R22's recliner chair. During interview on 11/2/23 at 10:52 a.m., the hospice RN stated, she just met R22 on	F 684		

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F 684	Continued From page 27 10/27/23, and was hopeful R22's wounds would heal and was dependent on her nutrition status. Hospice RN stated she just forwarded an email from the house hold coordinator (HHC)-C to check on the status of a wound cushion. During interview on 11/2/23 at 11:02 a.m., hospice RN stated she was not notified of a new wound and was not aware R22 was not sleeping in her bed and stated it would be important if R22 was in her chair to have an intervention for her recliner chair and further stated wound assessments were important to complete to make sure new interventions were put in place if the wound was not healing according to the plan. During interview on 11/2/23 at 12:34 p.m., hospice RN stated HHC-C sent her an email on 11/1/23, regarding a cushion and stated it was the first time she had heard about a cushion and further stated she ordered a standard cushion and the nursing facilities wound care team was taking care of the wounds and updating her on the wound measurements. During interview on 11/3/23 between 11:38 a.m., and 11:40 a.m., the director of nursing (DON) stated they talked about getting a cushion and hospice was going to provide it and they received the cushion on 11/2/23. DON further stated hospice was aware R22 was not sleeping in bed. A policy, Hospice Care Coordination dated November 2017, indicated the purpose of the policy was to provide guidance and clarity for facility staff to ensure coordination of care when a resident chooses to enroll in a Medicare or Medicaid approved hospice benefit program. The facility will continue to maintain 24 hour	F 684		

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F 684	Continued From page 28 accountability for the resident when a resident chooses the hospice benefit. This includes but is not limited to continue to meet the resident's personal and medical needs. The facility's services must be consistent with the coordinated plan of care developed with the hospice provider and the facility must continue to offer the same services to the resident who chooses the hospice benefit as they do to those who have not chosen the hospice benefit. The hospice provider maintains responsibility for provision of the hospice care and services based on the residents assessment and individualized needs including but not limited to: nursing to support the resident's ongoing care, provision of medical supplies and DME (durable medical equipment) and drugs necessary for palliation of pain and symptoms associated with the terminal illness. A communication process will be maintained 24 hours a day to ensure resident care.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		11/28/23

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F 686	Continued From page 29 by: Based on observation, interview, and document review, the facility failed to perform timely comprehensive skin assessments, and implement interventions to promote healing and reduce the risk for further pressure ulcer development for 1 of 2 resident (R22) who was admitted to the facility without pressure ulcers. This resulted in harm for R22 when the facility failed to develop interventions to promote healing and prevention resulting in R22 developing three pressure ulcers. Findings include: A stage one pressure injury is intact skin with a localized area of redness that is non-blanchable (does not turn white when pressed). A stage two pressure ulcer is partial thickness loss of the skin with exposed dermis, presenting as a shallow open ulcer. A stage three pressure ulcer is full thickness loss of the skin in which subcutaneous fat may be visible. Additionally, slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) or eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) may be visible but does not obscure the depth of the tissue loss. R22's Face Sheet form indicated the following diagnoses: unspecified protein calorie malnutrition, pressure ulcer of unspecified buttock stage three, major depressive disorder, and type two diabetes.	F 686	R 22 was comprehensively reassessed, and the care plan was updated. A recliner cushion was received from hospice the week of 10/30/23. The care plan and care sheets were updated. 11/16/23 Dietitian reviewed resident R22 for nutrition risk rational specifically for pressure injuries. No new recommendations and goals remain comfort focused. RD will continue with high-risk monitoring with pressure injuries present. ¿ All residents with current pressure ulcers had a comprehensive Pressure Injury Audit completed. All residents were audited for pressure relieving mattresses and pressure relieving cushions. All care plans were updated to reflect devices.¿Residents with recliners were reassessed for Braden Scores which focus on residents that may be at risk for pressure ulcers, completed 11/20/23. An audit will be completed on all current residents with pressure injuries to ensure all components of the policy are in place.¿ All residents will be audited to ensure that the appropriate cushions are in wheelchairs and chairs per care plan.¿¿ ¿ The Skin Integrity Management Policy was reviewed, no changes were made.¿¿All licensed staff were reeducated on the Skin Integrity Management policy which includes appropriate assessment, treatment, and interventions for wound care	

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F 686	Continued From page 30 R22's admission Minimum Data Set (MDS) dated 6/27/23, indicated intact cognition, did not reject care, required partial to moderate assistance with toileting, showering, was occasionally incontinent of bladder, was five feet tall and 105 pounds, was at risk of developing pressure ulcers and did not have one or more unhealed pressure ulcers at a stage one or higher. Under the section "Skin and Ulcer Treatments" R22 had a check mark next to applications of ointments and medications other than to feet. R22's significant change in status (MDS) dated 9/27/23, indicated R22 had moderate cognitive impairment, did not reject care, was occasionally incontinent of bladder, and frequently incontinent of bowel, was 104 pounds, was at risk for pressure ulcers and had one stage three pressure ulcer and under the section, "Skin and Ulcer Treatments" had a check mark next to pressure relieving device for R22's chair and bed, had nutrition or hydration intervention to manage skin problems, pressure ulcer care, and applications of ointments and medications other than to feet. R22's significant change in status (MDS) dated 10/11/23, indicated moderate cognitive impairment, did not exhibit behaviors, and did not reject care. Required substantial maximal assistance for toileting hygiene, partial moderate assist for moving from sitting to lying, and chair to bed to chair, and toileting transfers required supervision or touching assistance, was occasionally incontinent of urine and always continent of bowels. R22's weight was 101 pounds, was at risk of developing pressure ulcers and had two stage three pressure ulcers, and under the section, "Skin and Ulcer Treatments"	F 686	management. Bath audits will be reviewed to ensure compliance and identification of potential skin issues on 10% of residents weekly As well as expectation of the weekly bath audit.¿ Pressure injury audits and body audits will be completed on any newly acquired pressure ulcers or admitted residents and weekly on current residents with Pressure injuries for 12 weeks with QAPI support for anything under 90% or less. The Clinical administrator or designee will be responsible for monitoring compliance and reviewed by DON or designee who will present results in QAPI. Date Certain 11/28/2023	

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F 686	Continued From page 31	F 686		

had a check mark next to pressure reducing device for chair, bed, pressure ulcer care, applications of ointments and medications other than to feet.

R22's care plan dated 7/7/23, indicated an activity in daily living (ADL) self care performance deficit and required staff assistance due to limited mobility, impaired balance and an intervention included to observe skin for redness, open areas, scratches, cuts, bruises and report changes.

R22's care plan dated 7/7/23, indicated R22 had limited physical mobility and required staff assistance due to limited mobility and impaired balance. The care plan was later updated on 11/2/23, to include an intervention identifying R22 required assist of one to reposition in bed and assist of two to boost up in bed. This intervention further indicated R22 had an air pressure reduction mattress on the bed, and R22 preferred to sleep in the recliner and had an air pressure cushion. Prior to 11/2/23, the bed mobility intervention was last revised on 9/13/23, to include R22 required assist of 1 to reposition self in bed and encourage off loading in bed and chair.

R22's care plan dated 10/9/23, indicated an altered nutritional status due to weight loss and impaired skin integrity. Interventions indicated providing a diet as ordered, monitor intake, obtain weights, monitor lab work, honor food preferences and requests.

R22's care plan dated 10/13/23, indicated R22 was at risk for impaired skin integrity due to limited mobility, medication side effects, bladder incontinence, malnutrition and had two stage

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F 686	Continued From page 32 three pressure ulcers on the left buttock and coccyx. R22's goal indicated the current pressure ulcers would show signs of improvement by the next review date as evidenced by a decrease in size or a resolved status. Interventions indicated following facility protocols and policies for prevention of skin breakdown, a pressure reducing mattress, able to request assistance for toileting and repositioning, observe for signs and symptoms of breakdown and update the nurse promptly if noted. The most recent intervention on the care plan was dated 8/4/23, and indicated R22 required a pressure reducing wheelchair cushion. No new interventions were added following the development of new pressure ulcers. R22's care sheet dated 10/11/23, indicated R22 required assist of one with a transfer belt for transfers and ambulating short distances. Additionally, R22 required assist of one when going to the bathroom, and with dressing, grooming, and bathing and required a body audit completed on Thursdays, further, R22 required frequent repositioning and offloading while in the bed and wheelchair. The care sheet had a yellow highlighted instruction dated 8/4/23, to remind R22 to reposition off bottom for a few minutes every two to three hours due to having a pressure ulcer. The care sheet lacked any information or instruction resident had a cushion for the reclining chair. R22's Amount Eaten Task form dated 10/3/23, to 10/31/23, indicated variable appetite, however mostly ate 76-100% of meals. R22's nursing progress notes dated 6/21/23 at 12:25 p.m., indicated R22's skin was clean, dry,	F 686		

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F 686	Continued From page 33 and intact. R22's nutritional summary note dated 6/22/23 at 11:21 a.m., indicated R22 admitted to the facility with a wedge compression fracture, malnutrition, type two diabetes and consumed 76 to 100% at meals since admission. Additionally, the note indicated skin was clean dry and intact, and had a history of a pressure injury to R22's sacrum. An oral nutritional supplement (ONS) was discontinued due to refusals and a p.m. snack was added to promote intake. R22's nursing progress note dated 7/16/23 at 4:30 p.m., indicated R22 required an assist of one to transfer and usually self transferred and refused to be assisted and stayed in her recliner most of the time. R22 was checked changed and repositioned every two to three hours and as needed. R22's nutrition risk assessment dated 7/20/23, indicated R22 consumed 76 to 100% at most meals and received a p.m. snack every day with good acceptance and at times was sleeping and skipped the snack. Additionally, R22's weight on 7/19/23, was 110.2 pounds and was trending upwards which was desired due to malnutrition, but weight could fluctuate due to taking a diuretic medication. R22's nursing progress note dated 8/1/23 at 6:45 p.m., indicated a 1 inch stage two to three pressure ulcer on the right buttocks. The note indicated the coccyx, buttocks was macerated and erythematous and tender to touch and R22 was educated about frequent repositioning and sleeping in R22's bed versus the chair. The note indicated to continue to monitor and the next	F 686		

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F 686	Continued From page 34 registered nurse was updated. R22's nursing progress note dated 8/4/23 at 8:21 a.m., indicated a late entry wound assessment and R22's daughter was notified of a stage two wound on buttocks and the practitioner, dietician, and therapy were notified. R22's nursing progress note dated 8/15/23 at 10:32 a.m., indicated R22 had a change in condition and was sent to the emergency room. At 5:58 p.m., nursing progress notes indicated R22 was admitted to the hospital and the hospital stated R22 had multiple sores on her bottom. R22's nursing progress note dated 8/16/23, indicated R22 came back to the facility, was fatigued and had a triad hydrophilic wound dressing. (A paste that maintains an optimal wound healing environment and facilitates a natural debridement.) Documentation lacked information a wound assessment was completed upon return from the hospital and a wound assessment was not completed until 8/25/23. R22's culinary progress note dated 8/22/23 at 8:16 p.m., indicated R22 had a weight gain and was 112.6 pounds. R22's weight continued to increase as a result of a good appetite and would be appropriate to discontinue from high risk monitoring however the dietician noted a wound assessment from 8/4/23, indicating a pressure area to R22's coccyx and body audits indicated the wound remained present, however a more recent wound assessment was not available. R22's nursing progress note dated 9/26/23 at 3:46 p.m., indicated R22 had two pressure ulcers; one on the coccyx (tailbone), and one on the left	F 686		

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F 686	Continued From page 35 gluteal fold (the horizontal skin crease that forms below the buttocks). An additional progress note on 9/26/23, indicated R22 had a new pressure ulcer on her coccyx. R22's Order Summary Report form indicated the following orders: - 8/4/23 Boudreauxs butt paste external ointment 40% zinc oxide topical. Apply to buttock topically three times a day for pressure ulcer educate about not applying Vaseline to area; may use house supply of zinc oxide cream - 9/26/23 treatment for both open areas on buttocks (left gluteal fold, and below the coccyx area) to be done Monday, Wednesday, Friday, and as needed. Cleanse both buttocks open areas with normal saline, pat dry with gauze, use skin prep around both areas avoiding going into the wound, apply Manuka hd dressing directly in the wound and cover each area with a barrier film dressing every 1 hours as needed and replace dressing when soiled or if it falls off. During the month of 6/12/23 through 10/19/23, R22's completed body audit form indicated the following: - On 6/21/23, which indicated R22 had a trace of a healed pressure ulcer on her sacrum, with a small area of discoloration and required frequent reposition/offloading to avoid recurrence. - On 6/29/23, no skin concerns - On 7/2/23, skin was clean dry and intact clean, dry and intact (CDI) - On 7/6/23, skin was CDI. - On 7/13/23, R22 had blanchable redness to buttocks and skin was intact. - On 7/20/23, R22 had blanchable redness on gluteal folds, some parts were minimally	F 686		

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F 686	Continued From page 36 excoriated and butt paste was applied and the rest of R22's skin was CDI. - On 7/27/23, R22 had blanchable redness to buttocks and butt paste was applied. - On 8/3/23, R22 had blanchable redness on gluteal folds and noted excoriation on the left gluteal fold and Boudreauxs Butt Paste was applied and the rest of the skin was CDI. - On 8/10/23, R22 had blanchable redness to buttocks and excoriation on left gluteal fold and butt paste was applied. - On 8/16/23, under comments indicated pressure on left gluteal fold and surrounding areas were excoriated and wound treatment was in place. - On 8/24/23, body audit indicated R22 had a stage two pressure injury to the left gluteal buttock and treatment and monitoring was in place. - On 8/31/23, body audit indicated R22 had pressure on the left gluteal fold and blanchable redness on surrounding areas and wound treatment was in place. - On 9/7/23, the body audit form indicated a stage two pressure ulcer to the left gluteal fold and a hydrocolloid was applied after R22's shower. - On 9/14/23, R22 continued with the left gluteal fold pressure ulcer with blanchable redness on the surrounding areas. - On 9/21/23, The body audit form indicated the pressure injury to the left gluteal fold and no increase in size. - On 9/28/23, the body audit form indicated R22 had pressure ulcers on the coccyx and the left gluteal fold. - On 10/5/23, the body audit indicated two pressure ulcers to left buttock coccyx region. - On 10/12/23, the body audit indicated a pressure injury on both the coccyx and left gluteal fold were still present.	F 686		

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F 686	Continued From page 37 - On10/19/23,the body audit indicated a pressure injury on the coccyx and left gluteal fold. - On 10/26/23, the body audit indicated no new skin issues were observed and had a pressure injury on both the coccyx and left gluteal fold. The body audits lacked any kind of assessment of the wounds. R22's Bowel Bladder and Skin Risk assessment dated 7/16/23, indicated R22 stayed in her recliner most of the time. Additionally, R22's Bowel Bladder and Skin Risk assessment dated 9/25/23, indicated R22 self transferred to the bathroom and spent most of each shift in her recliner. The assessment indicated R22 self transferred and was occasionally incontinent of bowels and was checked, changed, and repositioned every 2-3 hours and as needed. R22's Skin and Wound Evaluation Assessment form indicated a skin and wound evaluation was completed on the following dates in the electronic medical record (EMR): - 8/4/23, a new stage two in-house acquired pressure ulcer to the coccyx measuring 0.6 centimeters (cm) long by 0.4 cm wide and was documented as not applicable for the depth, no tunneling (a passageway of tissue destruction under the skin) or undermining (destruction of skin tissue extending under the skin edges. The goal of care for the wound was documented as healable - 8/25/23, the coccyx pressure ulcer measured 0.7 cm long by 0.8 cm wide and had a depth of 0.5 cm and 10% of the wound contained slough. - 9/1/23, the coccyx pressure ulcer measured 0.7 cm long by 0.6 cm wide and the depth was not applicable and 10% of the wound contained	F 686		

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F 686	Continued From page 38 slough. - 9/18/23, the coccyx pressure ulcer now identified as a stage three ulcer measuring 0.8 cm long by 0.8 cm wide with a depth of 0.5 cm and 10% of the wound contained slough. Under the section labeled, "Additional Care" which included check boxes of various interventions such as cushion, air flow pad, or mattress with a pump, none was indicated. - 9/26/23, contained two wound assessments: At 8:29 a.m., a stage three coccyx pressure ulcer that measured 0.8 cm long by 0.8 cm wide by 0.5 cm deep. At 8:33 a.m., a stage three pressure area to the coccyx documented as "New" as of 9/26/23 and measured 1.1 cm long by 0.7 cm wide with a depth of 0.5 cm and 50% of the wound contained slough with 4 cm of redness to the surrounding tissue. A cushion, turning and repositioning program was indicated in the check boxes under the section, "Additional Care". - 10/2/23, at 1:47 p.m., indicated a stage three pressure ulcer to the coccyx that measured 1 cm long by 0.9 cm wide by 0.5 cm deep and contained 10% slough. - 10/10/23, at 1:24 p.m., indicated a stage three pressure ulcer to the coccyx that measured 0.8 cm long by 1.1 cm wide by 0.5 cm deep. At 1:23 p.m., a stage three pressure ulcer to the coccyx that measured 1.1 cm long by 0.9 cm wide and 0.5 cm deep and 10% of the wound contained slough. - 10/26/23, at 9:25 a.m., indicated a stage three pressure ulcer to the coccyx that measured 1.1 cm long by 11.1 cm wide by 0.3 cm deep. - 10/31/23, indicated a stage three pressure ulcer that measured 1.2 cm long by 1.0 cm wide and no depth. An additional form indicated 0.8 cm long by 0.8 cm wide by 0.5 cm deep.	F 686		

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F 686	Continued From page 39 The Skin and Wound Evaluation Assessment form identified each wound was located on the coccyx. A record request form was provided to the facility requesting all assessments related to skin and wounds since admission including picture assessments that identified each wound and their measurements, however the requested information was not entirely received. During interview and observation on 10/30/23 between 5:48 p.m., and 5:50 p.m., R22 stated she had irritation on her bottom that was hard to heal and stated they provided a pillow to use, and had not spoken with her about staying off her bottom. R22 had a circular cushion in another chair but did not have a cushion in the recliner R22 was in. R22 had a cushion in the wheel chair and additionally had an air mattress on her bed. R22's care sheet updated on 10/11/23, lacked interventions for a cushion in the recliner. During observation on 11/1/23 at 6:56 a.m., R22 was in her room in her reclining chair and her head was bent forward. During interview at 11/1/23 at 7:19 a.m., registered nurse (RN)-B stated R22 slept in her recliner 90% of the time and refused to sleep in the bed despite encouragement and added it was R22's choice. RN-B stated R22 was supposed to have a cushion in the chair she slept in. During interview and observation on 11/1/23 at 7:25 a.m., R22 was in the bathroom with staff and had a circular type cushion in her arm chair, but was not in R22's recliner chair where she slept. nursing assistant (NA)-B stated she had worked at the facility for two years and stated R22 slept in her chair. NA-B verified the circular cushion was	F 686		

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F 686	Continued From page 40 not in R22's recliner chair she slept in this morning when R22 got up and verified R22 did not have any type of cushion in her recliner when she assisted her to get up. NA-B stated they toileted and repositioned R22 and stated R22 was continent. NA-B offered to apply the circular cushion to R22's recliner chair and R22 accepted. NA-B stated as the day goes on, R22 got weaker and needed assist and stated R22 could shift positions in her chair and added they tried to push for R22 to sleep in the bed as much as possible. During interview on 11/1/23 at 10:19 a.m., NA-C stated R22 could not get out of the recliner by herself and when R22 stood, she pushes off, but cannot get up on her own and just rocks in her chair and needed assist. During interview on 11/1/23 at 12:54 p.m., licensed practical nurse (LPN)-B stated wounds were measured once a week and stated R22 had two pressure ulcers and one was near the coccyx and the other on the left gluteal fold. LPN-B clarified R22's left buttocks was deteriorating and stated it looked like it was deeper and like the wounds were not improving. LPN further stated the pressure ulcers were hard to heal because R22 did not get off her bottom and wasn't eating well. LPN-B stated R22 could get up to go to the bathroom by herself and added R22 slept in her recliner chair. During interview on 11/1/23 at 1:07 p.m., nurse manager (NM)-G stated she asked hospice about an offloading cushion for R22 at the care conference on 10/13/23, and added R22 received an air mattress for her bed, and a gel cushion for R22's wheel chair. NM-G verified the care conference note lacked information regarding a	F 686		

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F 686	Continued From page 41 cushion for the recliner chair. NM-G further stated R22 wished to only sleep in her chair and when asked about a circular cushion observed in R22's room, NM-G stated the cushion could have come from hospice and hoped the family brought in the cushion because hospice should notify the facility if they bring items in. NM-G further stated she had not followed up to see if interventions were effective and did not follow up to verify if a cushion was in place. During interview on 11/1/23 at 1:14 p.m., LPN-B verified no wound assessments were completed after 8/4/23, until 8/25/23. LPN-B stated from 10/10/23, to 10/26/23, they were missing a week of assessments. LPN-B further stated the problem with putting the cushion in the chair when they had therapy look at it, was the manufacturer wouldn't approve a cushion in the recliner because they couldn't guarantee it wouldn't slide out and that was why they asked hospice to look into it. During interview on 11/1/23 at 2:20 p.m., the health unit coordinator (HUC)-H verified the hospice notes in the paper chart and in the electronic medical record (EMR) lacked any information regarding a cushion or follow up on a cushion for the reclining chair. During interview and observation on 11/1/23 at 3:38 p.m., R22 was in her reclining chair with a pillow behind her back, but there was no cushion on the seat of the recliner chair. RN-F measured the wound on R22's left buttocks and was 1.6 cm long by 0.9 cm wide and 0.3 cm deep. RN-F measured the wound to R22's coccyx and was 1 cm long by 1 cm wide that included tunneling in the corner right inside corner that measured 0.4	F 686		

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F 686	Continued From page 42 cm at 1 O'clock. RN-F also stated R22 had a new stage one pressure injury to R22's right inner buttocks that measured 0.7 cm long by 0.9 cm wide. RN-F stated R22 did not want the cushion her daughter gave her and stated R22 didn't always use it and stated R22 was on a repositioning schedule and occupational therapy got R22 a special cushion she thought was the circular cushion. RN-F stated since R22 had a new wound they may have to do something different and verified that wound assessments were supposed to be done weekly and used to be completed on Wednesdays, but stated there had been some changes and verified wound assessments were documented in the chart and were missed. RN-F further stated if wounds are not monitored they are going to get worse because you cannot evaluate a wound if you are not assessing them and expected there to be interventions in place regarding R22's recliner chair. During interview on 11/2/23 at 8:11 a.m., the director of nursing (DON) stated she found a wound assessment in a file and provided four of five pages of a hand written note on a Body Audit form dated 10/16/23. The form indicated R22's left gluteal fold measured 0.8 cm long by 0.76 cm wide by 0.5 cm deep and the coccyx measured 0.57 cm long by 0.66 cm wide by 0.5 cm deep. During interview on 11/2/23 at 8:25 a.m., LPN-B stated she had the mobile application for documenting the wound assessment on her phone and it was deleted so the assessment dated 10/16/23, did not pull over and stated the assessment was completed on 10/16/23, and stated they were 100% paperless and verified prior to 10/16/23, R22 was missing several	F 686		

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F 686	Continued From page 43 wound assessments. During interview on 11/2/23 at 10:52 a.m., the hospice RN stated, she just met R22 on 10/27/23, and was hopeful R22's wounds would heal and was dependent on her nutrition status. Hospice RN stated she just forwarded an email from the house hold coordinator (HHC)-C to check on the status of a wound cushion. During interview on 11/2/23 at 11:02 a.m., hospice RN stated she was not notified of a new wound and was not aware R22 was not sleeping in her bed and stated it would be important if R22 was in her chair to have an intervention for her recliner chair and further stated wound assessments were important to complete to make sure new interventions were put in place if the wound was not healing according to the plan. During interview on 11/2/23 at 12:34 p.m., hospice RN stated HHC-C sent her an email on 11/1/23, regarding a cushion and stated it was the first time she had heard about a cushion and further stated she ordered a standard cushion and the nursing facilities wound care team was taking care of the wounds and updating her on the wound measurements. During interview on 11/2/23 at 12:46 p.m., nurse practitioner (NP)-J stated R22's albumen level (an indicator of nutritional status) was completed on 8/15/23, and was 3.7 which was within normal limits. NP added R22 sitting in general like she preferred to do, put her at increased risk, but not having a cushion in addition to the reclining chair could have contributed to worsening pressure ulcers and additional ones as well and further stated she would have expected weekly skin	F 686		

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F 686	Continued From page 44 assessments because even if there were no pressure ulcers, you want to see if there was one developing and once one was present, you want to make sure it doesn't worsen and if you have one pressure ulcer, you are at additional risk of getting another one. During interview on 11/2/23 at 1:27 p.m., DON stated wound assessments should be completed according to their policy of every seven days at a minimum and would have expected staff to document wound assessments and additional interventions in place knowing R22 did not want to lie in bed. During interview on 11/3/23 at 11:40 a.m., DON stated assessments were not getting completed and they were looking to adjust staff loads to include trained medication aides. A policy, Skin Integrity Management Policy dated October 2022, indicated it was the facility policy to properly identify, assess, and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers/injuries; to implement preventative measures; and to provide appropriate treatment modalities for pressure ulcers/injuries according to industry standards of care. A Braden scale was completed on admission and weekly to determine level of risk and regardless of the resident's total risk score, each risk factor and potential causes should be reviewed individually, addressed in the analysis and interventions implemented. Based upon findings of the clinical assessment in partnership with the resident and or family input, a care plan will be developed or modified to reflect alterations in interventions and implementation of new interventions specific to	F 686		

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	245637	A. BUILDING _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016

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F 686	Continued From page 45 the resident. When a non surgical wound is discovered a new Wound Assessment is documented in point click care that includes the onset of the skin condition, type of wound, location, date, stage, length, width and depth; wound base description, surrounding skin description and if present drainage, odor, undermining, tunneling, and or pain. Documentation on the wound using the wound assessment with a structured progress note generating from the assessment should be done at least weekly, or more frequently depending on the wound characteristics or type dressing used. Implement appropriate interventions and update care plan and nursing assistant assignment sheets. An avoidable pressure ulcer/injury means the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.	F 686		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		11/28/23

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F 755	Continued From page 46 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure residents received medications according to physician's orders for 1 of 1 resident (R2) reviewed for medications. Findings include: R2's quarterly Minimum Data Set (MDS) dated 8/7/23, indicated severely impaired cognition and diagnoses of dementia (severe) without behavioral distrubance, alzheimer's disease, anxiety disorder, and major depressive disorder. It further indicated R2 was totally dependent on staff for transfers and required extensive assistance with all other activities of daily living	F 755	R2 Medication orders were reviewed for accuracy, Medical Director was informed of med error and reviewed interventions and education. The provider proposed changing medication patch to pill form, resident family refused. DON and Clinical Coordinator reviewed all current residents with skin patch medications and verified that skin patches were addressed, and care plans were updated when appropriate. All new admission orders will be reviewed for transdermal medications. The Medication Administration and Medication Error policy have been reviewed and no changes made.	

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F 755	Continued From page 47 (ADL). R2's physician's orders (last revised on 10/27/23), included Rivastigmine patch 24 hour 9.5 milligrams (Mg)/24 hour (hr). Apply 1 patch transdermally one time a day for dementia, date and initial with black sharpie and remove per schedule. R2's care plan dated 7/31/23, indicated R2 was not able to self administer medications with an intervention for staff to set them up and admnister them per physician's orders. R2's medication variance report dated 8/19/23 indicated during a body audit registered nurse (RN)-C found 4 Rivistigmine patches (dated 8/16/23, 8/17/23, 8/18/23, 8/19/23) on R2's back. R2's medication variance report dated 8/26/23, indicated during a body audit RN-D found 2 Rivastigmine patches (one dated 8/26/23 and the second one was undated) on R2's back. R2's medication variance report dated 10/27/23, indicated family member (FM)-A discovered 2 Rivastigmine patches on R2's back. R2's progress note dated 8/19/2023 (Late Entry) indicated during weekly body audit, writer found 4 Rivastigmine patches on residents shoulders and neck. Vital signs stable (VSS), there was no adverse effect, medication variance report completed, power of attorney (POA), DON, clinical coordinator (CC), on-call nurse practioner (NP) notified. R2's progress note dated 8/26/2023 indicated R2 had a second patch of Rivastigmine found on the	F 755	All nurses will be educated in Medication Administration and Medication Error policies. Education for nurses through Microlearning will emphasize skin assessment/evaluations, the dating and initialing of medication patches, and how to communicate to licensed nurses. All nurses will receive education prior to shift after 11/28/23 Weekly medication administration audits will be performed by Clinical Coordinator on 10 % of residents for 8 weeks and include audits on R2 patch administration. DON or designee will be responsible for monitoring audits with a compliance goal of 90% or greater. DON or designee will present the results in QAPI, per the administrator. Date Certain 11/28/2023	

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F 755	Continued From page 48 right middle part of her back during the body audit. Writer assessed the left part of the body starting at the residents head and found it to be clear except for a new patch on the upper left side of R2's back signed and dated for today (8/26/23). When writer turned R2 to assess the right side, another patch was found on the middle part of her back . Writer could not determine the date and signature on the patch but it was labeled with the medication name (Rivastigmine). During an interview on 11/1/23 at 2:25 p.m. registered nurse (RN)-C stated he observed 4 Rivastigmine patches on R2's back. During an interview on 11/01/23 at 11:39 a.m., registered nurse (RN)-B verified on 8/27/23 she administered a Rivastigmine patch and failed to remove the patch from the previous day stating she assumed the night nurse had removed the patch already. RN-B further stated "I knew I had to remove the other patch, I just assumed it had already been removed." During an interview on 11/01/23 at 12:40 p.m., licensed practical nurse (LPN)-A verified she was involved in the medication errors discovered on 8/19/23 regarding R2's Rivastigmine patches. LPN-A stated she had placed a new patch without removing the old one for two days in a row. LPN-A further stated the next day was R2's shower day and was helping the evening shift get R2 ready and noticed three patches on her back. During an interview on 11/01/23 at 1:40 p.m., RN-E verified making a medication error (8/19/23) regarding R2's Rivastigmine patches stating she had applied a new patch without removing the old one and had assumed the aides	F 755		

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F 755	Continued From page 49 were removing them. During an interview on 11/2/23 at 11:45 a.m., the pharmacist stated Rivastigmine patches were used to help patients with dementia retain memories and help with attention. He further stated Rivastigmine can stay in a person's system for up to 30 hours and the adverse effects of having too much Rivastigmine could result in seizures, falls, and complete delirium. The Pharmacist stated he completed a review of R2's medications as a result of these errors and was unable to recall what the maximum dose per day was but that it was included on the report. R2's consultant pharmacist report dated 10/30/23, indicated R2 was receiving Rivastigmine patch 24 hour 9.5 mg/24 hours every day. It further indicated staff had not removed the old patch before placing a new patch and measures to prevent the error had failed multiple times. It also indicated a maximum daily doseage of 12 mg per day. During an interview on 10/31/23 at 10:56 a.m. the director of nursing (DON) verified there were three medication errors regarding R2's Rivastigmine patches since August (8/19/23, 8/26/23, 10/27/23). She stated upon investigating the errors they identified the problem and put interventions in place but the errors continue to occur and it doesn't appear to be a one staff issue. During an interview on 11/3/23 at 10:35 a.m., the administrator stated on 10/27/23, he observed two medication patches on R2's back. He further stated they have a system in place (to prevent these errors from occuring) and it seems like the	F 755		

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F 755	Continued From page 50 system should work but it's not. We keep adding things to fix the problem but it doesn't work. The administrator also stated he expected the nurses to follow the plan set in place and medication errors should not be occurring. The facility's medication administration policy modified on 5/21, indicated the facility will ensure safe, effective and timely drug therapy and provide an accurate and concise documentation system. It further indicated RN's, and LPN's will administer medications as ordered by the attending physician and/or nurse practioner.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		11/28/23

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F 756	Continued From page 51 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow up on pharmacy recommendations for 1 of 5 residents (R34) reviewed for unnecessary medications. Findings include: R34's quarterly Minimum Data Set (MDS) dated 10/20/23, indicated moderately impaired cognition, inattention, disorganized thinking and diagnoses of alzheimer's disease and major depressive disorder. It further indicated R34 required substantial assistance with activities of daily living (ADL), mobility, and received an antidepressant 7/7 days in the lookback period without attempting a gradual dose reduction (GDR) and not noted to be clinically contraindicated. R34's care plan dated 10/17/23, indicated R34 used antidepressant medication for depression with an intervention to consult with pharmacy and	F 756	On 10/31/2023 a pharmacy report was completed by the provider. The provider declined the pharmacy's recommendation. R 34, pharmacy recommendation dated 6/14/23 was completed on 10/31/23, the provider declined the recommendation, and no changes were made to the medication administration for R34. A facility audit was completed to verify completion of any potential outstanding pharmacy recommendations. As of 11/16/2023 there are no outstanding pharmacy recommendations per pharmacy report dated 11/16/2023. The Clinical Medication Review Policy was reviewed, and no changes made. Nurse leadership will be educated on the Clinical Medication Review policy. The DON will receive monthly pharmacy recommendation report and ensure	

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F 756	Continued From page 52 my physician to consider dosage reduction when clinically appropriate. R34's physician's orders dated 4/5/23, indicated Lexapro oral tablet 20 milligrams (Escitalopram Oxalate). Give 20 milligrams by mouth in the morning for major depressive disorder. R34's pharmacy consultation report dated 6/14/23, indicated R34 receives Escitalopram 20 milligrams (mg) daily for major depressive disorder (MDD), a dose which exceeds the maximum recommended daily dose of 10 mg daily in those 60 years of age and older. The resident also receives Quetiapine 100 mg every day at hour of sleep (QHS) for psychosis. It further indicated a recommendation to re-evaluate Escitalopram for risk versus benefit of current dose, considering a decrease to 10 mg daily if warranted. The pharmacy constultation lacked a physician's response to the recommendation. During an interview on 11/02/23 at 4:11 p.m., the director of nursing (DON) verified they had not received a response from the physician/NP regarding R34's pharmacy recommendation on 6/14/23 and did not follow up on it stating they had changed pharmacies and it was a "messy transition" and some of the older recommendations had "slipped through the cracks." A policy related to follow up on the consultant pharmacists recommendations was requested but not received.	F 756	provider responds to the recommendations per the policy. The Pharmacist, Medical Director and the Nurse Practitioner were given the policy to review on 11/22/2023, which includes following the medication regime guidelines, importance of communication and policies and procedures. Monthly audits will be performed on 10% of pharmacy recommendations once received from the monthly pharmacy review to ensure compliance x 3 months, the audit will also include the physicians' and pharmacists' recommendations. Monthly audits will be shared with physician and pharmacists. DON or designee will be responsible for monitoring compliance and results will be shared in QAPI, the pharmacist and medical director will give further guidance if the compliance is below 90%. The administrator will oversight ensuring compliance. Date Certain 11/28/2023.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/01/2023. At the time of this survey, NORRIS SQUARE 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		11/22/2023

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

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

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

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

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

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

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

NORRIS SQUARE is a 2 story building with no basement.

Norris Square was constructed in 2018 and was determined to be of Type II(222) construction.

The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored

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K 000	Continued From page 2 for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain cooking appliance per NFPA 101 (2012 edition), Life Safety Code section 19.3.2.5, 19.3.2.5.3 (9). This deficient finding could have	K 324	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a	12/15/23

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K 324	Continued From page 3 an isolated impact on the residents within the facility. Findings Include: On 11/01/2023 between 10:00 AM and 2:30 PM, it was observed in the Physical Therapy / Occupational Therapy Area that the residential stove did not have a 120 min time-out protective feature. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. The residential stove in the Physical Therapy /Occupational Therapy Area will be made to conform to the requirements of the NFPA 101 (2012) Life Safety Code section 19.3.2.5, 19.3.2.5.3 (9). A 120-minute time-out protective device will be installed by December 15th, 2023. The Environmental Services Director (ESD) will be responsible for ensuring this device is properly installed by the date certain. A recurring task to inspect and test this device semi-annually will be entered into the Electronic Work Order System by the Regional Engineer on or before December 15th, 2023.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		12/15/23

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K 345	Continued From page 4 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct sensitivity testing of the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that no documentation associated to fire alarm device sensitivity was available for review. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	The Fire Alarm Control Panel (FACP) constantly monitors the sensitivity status of the fire alarm system devices. A report of the status of the fire alarm system devices can be downloaded from the FACP at any time. To meet the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code, that records of system acceptance, maintenance and testing are readily available. (9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72) the annual Fire Alarm System inspection conducted by a qualified contractor will include downloading a copy from the FACP of the fire alarm system device sensitivity test at the time of the inspection. The ESD will be responsible for obtaining this inspection report and ensuring that it is readily available to the AHJ. The Regional Engineering Manager will check for this sensitivity testing report during the Annual facilities Review documentation inspection. The ESD will obtain a current copy of the sensitivity report from the FACP and place it with the Fire Alarm System inspection records	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		12/15/23

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K 353	Continued From page 5 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 5.1.1.1., NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section(s), 8.1, 8.5.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by observation that in the following resident rooms there were items stacked or stored vertically closer that 18 inches to the fire sprinkler head(s): RM 218 and RM114.	K 353	1. To meet the requirements of NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 5.1.1.1., NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section(s), 8.1, 8.5.6.the items stacked or stored vertically closer than 18 inches to the fire sprinkler heads in rooms 218 and 114 will be rearranged to be no closer than 18 from the sprinkler heads on or before December 15th, 2023. The ESD will be responsible for rearranging these stored items to meet the required distance. The ESD will conduct documented training with the housekeeping and engineering staff to be aware of and watch for the correct	

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K 353	Continued From page 6 2. On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that there was no documentation presented to confirm that quarterly inspections of the fire sprinkler system are being conducted. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	distance requirement of storage to sprinkler heads while they are conducting their duties in resident rooms by December 15th, 2023. 2. To meet the requirements of NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 5.1.1.1., NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section(s), 8.1, 8.5.6 the required quarterly inspections of the fire sprinkler system will be conducted and documented as required. The ESD or his proxy will be responsible for conducting these inspections are completed as required. A recurring task entry will be made in the Electronic Work Order System by the Regional Engineering Manager by December 15th, 2023, The Regional Engineering Manager will review the documentation for these quarterly inspections during the document review portion of the Annual Facility Review	
K 355 SS=F	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	K 355		12/15/23

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K 355	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly inspect, and maintain fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.1.2.2, 7.2.1.2, 7.2.4.3, 7.2.4.4, 7.2.4.5,, 7.3.1.1.1, 7.3.2.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by observation, that the following fire extinguishers were not inspected in October 2023: CC L2 01 / 06 / 07 / 08 / 09 and CC L1 07 / 08 / 09 / 10 / 11 / 12 / Sprinkler Riser Room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355	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 Based on observation and staff interview, the facility failed to properly inspect, and maintain fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.1.2.2, 7.2.1.2, 7.2.4.3, 7.2.4.4, 7.2.4.5,, 7.3.1.1.1, 7.3.2.4 To meet the requirements for maintaining portable fire extinguishers, the ESD shall be responsible for ensuring the monthly inspection checklist is current and complete, and that the monthly inspection is completed by the ESD or his proxy by December 15th, 2023. The ESD will conduct an annual audit of fire extinguishers during the annual inspection to ensure no fire extinguishers have been unaccounted for. A recurring task for this annual audit will be entered into the Electronic Work Order System by the Regional Engineering Manager by December 15th, 2023 The Regional Engineering Manager will spot check fire extinguisher inspection cards during the Annual Facility Review.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		12/15/23

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K 372	Continued From page 8 Construction 2012 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and inspect smoke / fire dampers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.5, and 8.6.7.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that no documentation was present to confirm that fire / smoke damper testing in occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	To meet the requirements of NFPA 101 (2012) Life Safety Code sections19.3.7.3, 8.5.5, and 8.6.7.1 the 4-year fire/smoke damper test and inspection will be completed by December 15th, 2023. The ESD shall be responsible for ensuring this requirement is met. A recurring task shall be entered into the Electronic Work Order System by the Regional Engineering Manager by December 15th, 2023.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		12/15/23

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K 712	Continued From page 9 conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that a fire drill(s) were conducted for 1st shift or 3rd shift for 3rd quarter. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 712	Fire Drills will be conducted at least quarterly on each shift at expected and unexpected times and varying conditions as required per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. The ESD or his proxy will be responsible for conducting fire drills in a timely manner. The ESD will develop a yearly schedule in Outlook Calendar indicating times and places where fire drills will be held by December 15th, 2023. He will share this calendar with the Campus Administrator and the Regional Engineering Manager by December 15th, 2023. The safety committee will review fire drills each meeting for the previous period for compliance and training. The Regional Engineering Manager will review the fire drill reports during the document review portion of the Annual Facility Review.	
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.	K 761		12/15/23

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K 761	Continued From page 10 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 document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that the most recent fire rated doors / assemblies inspection was completed 10/28/2022. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	The requirement for inspecting fire rated doors in the NFPA 101 (2012) Life Safety Code and NFPA 80 (2010 edition), sections 5.2.1. will be met by December 15th, 2023, and annually thereafter. A recurring task will be entered into the Electronic Work Order System by the Regional Engineering Manager by December 15th, 2023, with the new cadence based on the conclusion of the current testing. The ESD or his proxy will be responsible for properly conducting this inspection by December 15th, 2023. The Regional Engineering Manager will ensure that the door inspections were completed during the documentation review portion of the Annual Facility Review. The safety committee will annually review the door inspection documentation.	
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	K 914		12/15/23

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K 914	Continued From page 11 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 electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that the most recent electrical outlet testing was completed 10/25/2022 and did not include the testing of all outlets in the resident room(s). An interview with the Maintenance Director	K 914	The requirement for testing electrical receptacles at patient bed and care locations in per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. will be met by December 15th, 2023, and annually thereafter. A recurring task will be entered into the Electronic Work Order System by the Regional Engineering Manager by December 15th, 2023, with the new cadence based on the conclusion of the current inspection. The ESD or his proxy will be responsible for conducting this inspection by December 15th, 2023. The ESD will be responsible for ensuring that all receptacles which require inspection are inspected annually. The Regional Engineering Manager will ensure	

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K 914	Continued From page 12 verified this deficient finding at the time of discovery.	K 914	that the annual receptacle inspections were completed during the documentation review portion of the Annual Facility Review. The safety committee will annually review the door inspection documentation. The ESD will be responsible for ensuring that electrical receptacles are inspected after any service or replacement work is done.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923		12/15/23

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K 923	Continued From page 13 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by observation in the Med Gas (O2) Storage Room, mixed storage of empty / full cylinders. 2. On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by observation that in the Med Gas (O2) Storage Room was found unsecured. 3. On 11/01/2023 between 10:00 AM and 2:30 PM, it was revealed by observation that in the Med Gas (O2) Storage Room was found combustible storage. An interview with the Maintenance Director verified these deficient findings at the time of	K 923	1. To comply with the requirements of NFPA 99 (2012 edition), Health Care Facilities Code, sections11.6.5. the Med Gas cylinders in the Med Gas storage room will be segregated by whether the cylinders are full or not full (empty). All cylinders that are not full will be considered empty. All Med Gas cylinders will be labeled FULL or Empty and the FULL and EMPTY cylinders will be stored upright in separate racks. The ESD or his proxy will be responsible for maintaining this separation. A weekly recurring task to inspect the Med Gas storage room for compliance will be entered into the Electronic Work Order System and the ESD or his proxy will be responsible for ensuring the task is completed in a timely manner. The Med Gas storage room will be inspected for compliance by the Regional Engineering Manager during the building inspection portion of the Annual Facilities Review. 2. To comply with the requirements of NFPA 99 (2012 edition), Health Care Facilities Code, sections11.6.5, the Med Gas storage room door will be always	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245637	A. BUILDING **01 - PRESBYTERIAN HOMES OF COTTAGE GROVE** B. WING _____	**11/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIS SQUARE	**6993 80TH STREET SOUTH COTTAGE GROVE, MN 55016**

(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 923	Continued From page 14 discovery.	K 923	kept closed and securely locked. The ESD will be responsible for ensuring the room can be made secure by December 15th, 2023. The ESD will train the housekeeping and engineering staff to always be aware of the Med Gas storage room door security by December 15th, 2023. During the weekly task by engineering staff to check the storage of the Med Gas cylinders, the door security will be checked. 3. To comply with the requirements of NFPA 99 (2012 edition), Health Care Facilities Code, sections11.6.5, no combustible storage will be allowed in the Med Gas storage room. During the weekly task to check the Med Gas storage room cylinder storage and door security, the engineering staff will also inspect for combustible storage and remove if found. The ESD or his proxy will be responsible for ensuring this weekly task is completed in a timely manner.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2024

Administrator
Norris Square
6993 80th Street South
Cottage Grove, MN 55016

RE: CCN: 245637
Cycle Start Date: November 3, 2023

Dear Administrator:

On November 14, 2023, we notified you a remedy was imposed. On December 21, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 15, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 29, 2023 be discontinued as of December 15, 2023. (42 CFR 488.417 (b))

In our letter of November 14, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 29, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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