Electronically delivered
April 20, 2022

Administrator
Augustana HCC Of Apple Valley
14650 Garrett Avenue
Apple Valley, MN 55124

RE: CCN: 245264
Cycle Start Date: March 31, 2022

Dear Administrator:

On March 31, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS 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:

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 1, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 2022.

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 $11,292; 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 July 1, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Augustana Hcc Of Apple Valley will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 1, 2022. 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 September 30, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245264	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 550	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 1 of 1 resident (R43) who voiced they we being served meals with plastic dishware and cutlery which they disliked and felt was undignified. Findings include: R43's quarterly Minimum Data Set (MDS), dated 1/26/22, identified R43 had moderate cognitive impairment and required set-up support for eating. On 3/28/22 at 6:51 p.m., R43 was seated in his room waiting for the supper meal to be served. R43 explained he did not feel the facility staff treated him with respect and dignity as he was repeatedly being served his meals in his room on plastic on Styrofoam dishware with plastic cutlery which had been happening "awhile." R43 stated he would then have to ask staff for "real silverware" but would only sometimes receive it and expressed being served on these plastic items made him feel "like I'm a baby." However, during this interview R43 was served his supper meal tray with ceramic plates and metallic silverware being provided.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245264	A. BUILDING: _____ B. WING _____	3/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 550	Continued From Page 1

When interviewed on 3/30/22 at 9:45 a.m., nursing assistant (NA)-B stated she routinely worked with R43 and explained she had noticed meals on the unit were served using "sometimes on hard plates" and "sometimes on plastic [dishware]." NA-B stated it was not just R43's meals which were served on plastic but rather "everyone gets it," and she was unsure why meals were being served in such manner. NA-B stated she last observed plastic dishware and utensils be used on Monday morning (3/28/22) for the breakfast meal, however, then the survey team entered and she had not seen them used again since, instead all meals were now being served on and with regular dishware. Further, NA-B stated R43 had expressed he disliked using plastic dishware and added, "[R43] tells me he doesn't like those."

On 3/30/22 at 10:42 a.m., the certified dietary manager (CDM) was interviewed. The CDM explained the kitchen was using Styrofoam or plastic dishware and cutlery when they were short staffed as it reduced the labor burden to use disposable items, and she verified they switched to ceramic dishware and metal cutlery when the survey team entered on 3/28/22. A corresponding Dates That Paper Disposables Were Used Due To Staffing Shortage listing, dated 2/1/22 to 3/29/22, was provided which outlined each date plastic and/or disposable items were used to serve meals to the residents. These dates included: 2/1/22, 2/6/22, 2/11/22, 2/12/22, 2/13/22, 2/14/22, 2/15/22, 2/18/22, 2/19/22, 2/20/22, 2/25/22, 2/26/22, 2/27/22, 2/28/22, 3/1/22, 3/2/22, 3/13/22, 3/18/22, 3/19/22, 3/20/22, 3/21/22, 3/22/22, and 3/29/22, totaling 23 out of 57 days.

When interviewed on 3/30/22 at 11:02 a.m., registered nurse unit manager (RN)-D stated she had seen plastic or Styrofoam dishware being used "a little more lately" on the unit for meals and was "not sure why." RN-D stated she could not recall if R43 had voiced any concerns with this directly to her but expressed dishware and cutlery for meals "should be regular [ceramic]" to promote a homelike dining experience.

A facility' policy on homelike and/or dignified dining experience was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 3/28/22 to 3/31/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop	E 004		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	03/31/2022

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E 004	Continued From page 1 and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to review the Emergency Action Plan (EAP) annually in accordance with the requirements of CFR 483.73. This had the potential to affect all 122 residents currently residing in the facility. Findings include: Review of the facility EAP lacked a signature	E 004		

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E 004	Continued From page 2 page or other indication it had been reviewed in the previous year. Further, no documentation was provided to indicate the EAP had been reviewed by the Quality Assurance and Performance Improvement (QAPI) committee in the previous year. During an interview on 3/31/22, at 10:04 a.m. the administrator verified he was unable to provide documentation to indicate the EAP had been reviewed the previous year.	E 004		
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.	E 013		

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E 013	Continued From page 3 *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to develop and	E 013		

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E 013	Continued From page 4 implement policies and procedures required under CFR 483.73, to include: the use of volunteers in an emergency and tracking staff during an emergency. In addition, the facility failed to ensure emergency policies and procedures were reviewed and/or revised annually. This had the potential to affect all 122 residents, as well as all staff and volunteers who worked in the facility. Findings include: Review of the facility all hazards assessment dated 2/26/20, indicated it had not been reviewed or revised annually. The assessment indicated the likelihood of a pandemic was a moderately likely (2) on a scale of 0 to 3. Review of the following policies also indicated they were not reviewed or revised annually: -Emergency Water Supply and Use dated November 2019. -Electrical Power Outage dated November 2019. -Disruption of Services dated November 2019. -Food and Nutrition Services Emergency Preparedness dated 2/18/19. -Internal Disaster Plan dated November 2019. -Sheltering in Place dated November 2019. During an interview on 3/31/22, at 10:04 a.m. the administrator stated all hazards assessment had not been reviewed annually and the likelihood of a pandemic should have been coded a 3 (high) instead of a 2 (moderate). The administrator was also unable to provide documentation indicating the listed policies and procedures had been reviewed or revised annually.	E 013		
E 018 SS=C	Procedures for Tracking of Staff and Patients	E 018		

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E 018	Continued From page 5 CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.	E 018		

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	245264	A. BUILDING _____ B. WING _____	03/31/2022

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E 018	Continued From page 6 *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.	E 018		

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E 018	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement emergency preparedness policies and procedures that included a system to track on-duty staff during evacuation in the case of an emergency, this had the potential to affect all 122 residents currently residing the facility as well as staff. Findings include: Review of the facility Emergency Preparedness Program did not include a policy or procedure to track the location of on-duty staff that would require evacuation during an emergency. Review of the facility Evacuation Plan for the full-scale drill held on 3/24/22, indicated all residents evacuated from the facility would be accompanied by designated staff to a designated mode of transportation. The plan also indicated a designee would track resident locations post-evacuation, however, the plan lacked indication for tracking on-duty staff. During an interview on 3/31/22, at 10:04 a.m. the administrator confirmed the facility did not have a process in place to track on-duty staff and their whereabouts during an emergent evacuation of the facility.	E 018		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5),	E 024		

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E 024	Continued From page 8 §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure their emergency	E 024		

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E 024	Continued From page 9 preparedness plan (EPP) addressed the use of volunteers in an emergency including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This had the potential to affect all 122 residents who resided in the facility. Findings include: During review of the facility EPP, the policies and procedures did not include the use of volunteers in an emergency, or other emergency staffing strategies that utilized volunteers to address surge needs in an emergency. During interview on 3/31/22, at 10:04 a.m. the administrator stated the EPP did not contain a policy or procedure that addressed the training of and use of volunteers during an emergency or other emergency staffing strategies that involved the use of volunteers.	E 024		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of	E 041		

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E 041	Continued From page 10 this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

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

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E 041	Continued From page 12 Based on observation, a review of available documentation review and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13, NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1, 8.3, 5.6.5.6, 5.6.6, 5.6.5.2(4), and NFPA 70 (2011 edition), National Electrical Code, sections 110.1, 110.26, 110.26(A)(1), 110.26(C)(1) This deficient condition could have a widespread impact on the residents within the facility. Findings include: During visual inspection by the state fire marshall on 03/30/2022 between 09:30 a.m. to 02:30 p.m, it was revealed during the walk-through of the facility, that the generator emergency stop was located on an electrical panel in mechanical room. Access to the generator emergency stop was fully obstructed at the time of inspection. In addition, on 03/30/2022 between 09:30 a.m. to 02:30 p.m., it was revealed by a review of the most recent vendor annual on-site inspection report (Cummins 03/15/2021), that the technician noted the battery age was at that time in excess of 2 years. In addition, on 03/30/2022 between 09:30 a.m. to 02:30 p.m., it was revealed during the walk-through of the facility that the generator remote annunciator panel located in the area of the 1st floor Nursed Station did not function or illuminate upon testing. It could not be confirmed that the generator remote annunciator panel was operational. During an interview on 3/31/22, at 10:04 a.m. the administrator confirmed the emergency generator	E 041		

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E 041	Continued From page 13 back-up battery had not been replaced in over two years. The administrator did not provide any further information regarding access to the emergency stop or the operational status of the generator remote annunciator panel.	E 041		
F 000	INITIAL COMMENTS On 3/28/22 to 3/31/22, a standard recertification survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		

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F 684	Continued From page 14 by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to promote comfort with poor wheelchair posture and worsening hemorrhoids for 1 of 2 residents (R39) reviewed for positioning and quality of care. In addition, the facility failed to ensure 1 of 1 resident (R472) had weights monitored in accordance with physician parameters to prevent complication of associated medical conditions. In addition, the facility failed to coordinate with an outside orthopedic clinic to adequately monitor a surgical wound to ensure healing and reduce the risk of complications for 1 of 1 residents (R375) who admitted after surgery. Findings include: R39's quarterly Minimum Data Set (MDS), dated 1/19/22, identified R39 had intact cognition, used a wheelchair for mobility, and required supervision to completed most activities of daily living (ADLs). On 3/28/22, at 3:07 p.m. R39 was seated in a standard wheelchair in her room. R39 appeared to be slouched in the wheelchair with her buttocks positioned towards the front of the wheelchair cushion and her arms extended upward to rest on the provided wheelchair armrests. R39 was interviewed at this time and expressed she did not like her wheelchair as it was, "about 20 years old and falling apart." R39 stated she tried using a black cushion to help improve her positioning in the chair awhile back, and pointed to it stored against the wall and her cabinet; however, stated it did not help much. R39 stated she had never been screened or evaluated for her wheelchair	F 684		

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F 684	Continued From page 15 positioning to her knowledge but added, "I wish they would." During subsequent observation on 3/29/22, at 11:55 a.m. R39 continued to use the same standard wheelchair and continued to appear slouched back with her arms having to be extended upward to rest on the provided arm rests. R39 denied any discomfort from sitting in such position at this time. R39's care plan, last revised 1/26/22, identified R39 used a manual wheelchair for mobility and was independent with it's use. The care plan lacked any dictation or documentation on R39's positioning while seated in the wheelchair or if she had ever been evaluated by therapy for such; nor any information on the use of the black cushion present in R39's room which, according to R39, had been trialed in the past for her wheelchair positioning without success. When interviewed on 3/30/22 at 9:19 a.m., nursing assistant (NA)-C stated she had worked at the nursing home for "about a month" and had noticed R39 seemed to appear slouched in her wheelchair with her arms having to extend upward at the shoulder to rest on the armrests even when repositioned. NA-C described R39's posture as, "[she] shlumped back" in the chair and expressed R39's posture and positioning in the wheelchair had been such since she started working there. NA-C stated she was unaware of the black cushion present in R39's room and expressed she had never used it with R39 prior. Further, NA-C stated she had not reported any concerns about R39's posture in the wheelchair as R39 expressed she "is fine" with it and NA-C felt, overall, R39 "barely shlumps" while seated in	F 684		

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F 684	Continued From page 16 the wheelchair. During interview on 3/30/22, at 9:58 a.m. NA-B expressed she had worked with R39 for several months and had noticed her positioning in the wheelchair was poor and caused R39's back to hunch back when she was seated in the device. NA-B stated she had even told R39 "you're not sitting right" several times before and added she was unaware of the black cushion, nor any use of it, in R39's room. Further, NA-B stated she was unsure if therapy had ever worked with R39 on wheelchair positioning in the past but added, "Not that I know of." R39's medical record was reviewed and lacked evidence R39 had been comprehensively assessed or screened for her wheelchair positioning despite having a poor posture which had been observed by direct care staff for at least a month prior. On 3/30/22, at 10:30 a.m. registered nurse unit manager (RN)-D stated she had noticed R39 appeared "a little slouched" while seated in her wheelchair; however, had not worked with occupational therapy (OT) for this concern to her knowledge adding, "I don't think we've done any wheelchair mapping on her." RN-D expressed she was unaware of the black cushion in R39's room, nor when or how it was used, for R39's positioning in the past and voiced if staff were seeing concerns with R39's positioning they should bring those forward. Further, RN-D voiced it was important to ensure good wheelchair positioning was maintained as poor posture or positioning could be "a safety concern" and to reduce the risk of kyphosis (an abnormally curved spine) or other concern.	F 684		

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F 684	Continued From page 17 When interviewed on 3/31/22, at 10:21 a.m., occupational therapist (OT)-A stated she had worked at the nursing home for "over a year" and R39 had not been evaluated for wheelchair positioning to her knowledge. OT-A stated any concerns with wheelchair positioning should be evaluated and the medical provider updated so orders for OT to evaluate them can be obtained. OT-A added it was important to ensure wheelchair positioning concerns were addressed timely as poor posture could lead to back pain and interventions could "get more complicated" the longer the issue is allowed. A facility' policy on wheelchair positioning was requested; however, none was received. R39's quarterly Minimum Data Set (MDS), dated 1/19/22, identified R39 had intact cognition and required supervision to completed most activities of daily living (ADLs). On 3/28/22, at 3:03 p.m. R39 was interviewed and expressed she had hemorrhoids which seemed to be worsening and quite painful at times with increased bleeding noticed as of late. R39 stated she thought there was some medication she was taking for them; however, it was not routinely being given. When interviewed on 3/30/22, at 9:19 a.m. nursing assistant (NA)-C stated R39 had reported concerns to her about a month prior about her worsening hemorrhoids. R39 had expressed her buttocks "just hurt" because of them which caused NA-C to observe R39's rectum which exposed "a prolapsed hemorrhoid," so she reported the concern to the floor nurse who was	F 684		

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working. Further, NA-C stated she was not aware of any medication being placed or given to help R39 with the issue and associated discomfort.

R39's medical record was reviewed and lacked any evidence R39's worsening hemorrhoids had been assessed or interventions developed to reduce and/or eliminate them or the associated discomfort from them despite direct care staff having knowledge of the issue.

On 3/30/22, at 10:30 a.m. registered nurse unit manager (RN)-D was interviewed and expressed she was unaware R39 had been having issues with her hemorrhoids. RN-D explained if a resident has such issues, then staff should report it so the nursing staff can go in to "check the area" and coordinate a treatment plan with the medical provider which could include the use of Tuck Pads or other cream-based products. RN-D reviewed R39's Medication Administration Record (MAR) and verified there had been no treatments for R39's hemorrhoids in the past few months, nor was there any evidence in the medical record the issue had been assessed or addressed. RN-D stated the reported worsening hemorrhoids should have been addressed right away as the condition could worsen.

A facility' provided Change In Condition policy, dated 2/2020, identified the nurse would notify the attending physician or on-call physicians with several scenarios listed including, " ... need to alter the resident's medical treatment significantly." However, prior to such notification, the policy directed, " ... the nurse will make detailed observations and gather relevant and pertinent information (complete SBAR; Situation Background Assessment and Response) for the

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F 684	Continued From page 19 provider." R472's physician progress note printed 3/31/22, indicated R472 was admitted 3/23/22, with diagnoses of edema and chronic heart failure. R472's provider orders dated 3/23/22, indicated daily weights and a call to the provider for weight gain of more than 2 pounds per day, or 5 pounds per week. R472's weight log, medication administration record (MAR), and progress notes printed 3/31/22, indicated R472 was not weighed 2 of 8 days from 3/23/22, to 3/31/22. R472's care plan dated 3/23/22, indicated daily weight and report increases in weight to provider greater than 2# in one day, or 5# in one week. When interviewed on 03/29/22, at 11:29 a.m. R472 stated her legs were swollen and she was supposed to have daily morning weights, but staff was not weighing her daily. R472 stated she was concerned about not getting daily weights because her torsemide (medication to reduce fluid retention) dosing depended upon her weight. Further, R472 indicated she was more short of breath while sitting which she stated was due to excess fluid. R472 stated she was not normally short of breath unless she was walking. When interviewed on 3/29/22, at 10:57 a.m. licensed practical nurse (LPN)-A stated the resident had an order for daily weights, and they had not been done as ordered. When interviewed on 3/30/22, at 8:25 a.m. registered nurse (RN)-F confirmed the weights	F 684		

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F 684	Continued From page 20 were not recorded daily, and did not know why. When interviewed on 3/31/22, at 11:04 a.m. the acting director of nursing (DON) stated the expectation was that nursing assistants would get the daily weights as ordered, report them to the nurse, and the nurse would record them in the medical record. The DON stated the policy was to follow the orders as written, and if they were not, the resident could have fluid overload, heart complications, and increased edema. The facility's Weight Measurement policy revised 6/17/20, indicated weigh each resident monthly unless specifically ordered by physician to occur more often, and to record the weight in the electronic medical record. R375's admission MDS dated 3/23/22, identified cognitively intact, did not reject cares, required extensive assistance for most activities of daily living (ADL's) had a knee replacement and required surgical wound care. R375's care plan dated 3/18/22, identified a surgical incision on right knee and directed staff to complete a body audit and weekly skin observation. Staff were also to monitor for signs of infection or not healing and were to update the provider as needed. R375's Physician Order Report dated 3/18/22, indicated R375 was to take doxycycline hyclate 100 mg every 12 hours; at 12:00 a.m. and 12:00 p.m. until 3/21/22, for the presence of an artificial knee joint. The orders also indicated to follow up with orthopedics as instructed, however, no	F 684		

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F 684	Continued From page 21 instructions were included and no follow up was scheduled. R375's Visual Body Inspection dated 3/18/22, lacked any mention of R375's surgical incision. R375's Visual Body Inspection dated 3/24/22, lacked any mention of R375's surgical incision. R375's Comprehensive Skin Risk with Braden (a scale used to measure a resident's risk for pressure injuries) assessment dated 3/25/22, was incomplete and lacked a Braden score or any assessment or observation regarding R375's risk for pressure injury other than R375's need for assistance with ADLs. The "surgical wound" box listed in section "Other Skin Concerns" was also left unmarked. R375's Physician Order Report indicated: -3/18/22, R375 was to follow up with orthopedics as instructed, however, no instructions were included. -3/21/22, Consult with onsite orthopedic nurse practitioner (NP)-A for a follow up regarding R375's right knee surgery, however, there was no evidence NP-A was not notified for a consult. R375's Physician Note dated 3/25/22, indicated R375 complained of pain and limited mobility to her right knee. The note also acknowledged R375 had not attended her previously scheduled follow up appointment with the orthopedic surgical team and that R375 did not believe it had been rescheduled. The note further indicated medical doctor (MD)-A would follow up with the surgeon regarding the removal of R375's surgical dressing since it had not been removed since the surgery on 3/9/22.	F 684		

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F 684	Continued From page 22 During an interview and observation on 3/28/22, at 2:13 p.m. R375 stated she had a revision of her right total knee replacement on 3/9/22. R375 was discharged home after her surgery on 3/10/22. R375 had a follow up appointment with the surgical team scheduled for 3/22/22, however, on 3/16/22, she went to the emergency department due to extreme pain in her feet and ankles. R375 remained in the hospital for 2 days and was released to the facility for rehabilitation, on 3/18/22, with a diagnosis of gouty arthritis unrelated to her surgery. R375 stated after arriving at the facility, she looked at her online medical portal (MY Chart) to verify her follow up appointment but saw it had been canceled. R375 stated she had not canceled the appointment and was not sure who had. R375 also stated, to her knowledge, the follow up appointment had not been rescheduled. R375 stated her surgical bandage was to remain on her right knee until the follow up appointment, however, since she never went to the appointment, the bandage was still on her knee and had not been removed or assessed by the facility staff. R375 was observed to have a white bandage approximately 6 inches long and 2 inches wide with clear adhesive over top that extended approximately one inch wider than the bandage on all sides, on her right knee. The bandage was intact and appeared clean and dry. The skin surrounding R375's bandage was extremely dry, white and flaky, but otherwise intact with no redness or swelling noted. No part of the surgical incision was visible under the bandage. R375's progress noted dated 3/28/22, at 9:51 p.m. indicated the dressing to R375's right knee was removed, and no redness, drainage, or signs	F 684		

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of infection were noted. The incision was left open to air.

During an interview on 3/29/22, at 11:32 a.m. R375 stated the surgical bandage had been removed by a nurse the previous evening.

During an interview on 3/30/22, at 11:22 a.m. Twin City Orthopedics (TCO) care coordinator (CC-A) stated because R375's follow up appointment with the surgical team had been canceled, NP-A should have been notified and R375's surgical incision should have been assessed for signs of infection and dehiscence. CC-A further stated she wanted the staff to take a picture of R375's surgical incision and send it to the surgical team so they could assess it before R375 discharged home that afternoon.

During an interview on 3/30/22, at 12:18 p.m. Fairview surgical CC-B stated R375's follow up appointment on 3/22/22, would have been canceled by the facility because the post operative follow up is important and the surgical team would not have canceled it.

During an interview on 3/30/22, at 8:57 a.m. facility physician's assistant (PA)-A stated when she saw R375 on 3/21/22, she did not assess R375's knee because the surgical bandage was still covering it. PA-A stated because R375 was discharged to her private home after surgery, many of R375's post-op and discharge orders were missed by the facility. PA-A stated if R375 had been admitted to the facility immediately after her knee surgery, R375 would have been assessed by the facility onsite orthopedic NP-A. However, because R375 came in with a diagnosis of gouty arthritis, those orders were

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missed. PA-A also stated she did not know who canceled R375's follow up appointment with the surgical team on 3/22/22. PA-A further stated she was unaware that R375's surgical dressing had not been removed and the incision site assessed until the evening of 3/28/22. PA-A stated there would have been concern that the incision could have dehisced (a complication causing the incision to separate and open) or become infected if it had not been assessed for almost three weeks after the surgery was performed.

During an interview on 3/30/22, at 12:32 p.m. MD-A verified the order on 3/21/22, to consult with NP-A. MD-A did not know why that was not done and the facility should have followed up on it. MD- A also stated she had seen R375 on 3/25/22, and noted the surgical dressing from 3/9/22, was still on R375's right knee.

The facility Skin Integrity policy dated 2/4/21, indicated licensed staff would perform a head-to-toe inspection of their skin upon admission to the facility and document their findings in the resident's electronic medical record (EMR). The care plan and interventions to treat existing skin concerns would be implemented based on the resident's skin risk assessment and communicated to the nursing assistants (NAs) via assignment sheets. Licensed staff were to complete a head-to-toe assessment of the resident's skin and document findings in the EMR. NAs were to perform daily skin checks during routine cares and report concerns a licensed nurse. Resident skin alterations were to be documented in the EMR and include the alteration's location, a description of the skin, up to 4 centimeters (cm), surrounding the wound.

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 26 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure staff wore appropriate personal protective equipment (PPE) and performed hand hygiene for 2 of 2 residents (R68, R120) on enteric, contact precautions for Clostridium difficile (C-Diff-an infection of the large intestine caused by long-term antibiotic use that can be serious and life threatening, that is highly contagious). This had the potential to effect	F 880		

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F 880	Continued From page 27 all 19 residents on the unit being cared for by the same staff. Findings include: R68's admission Minimum Data Set (MDS) dated 2/22/22, indicated R68 had moderate cognitive deficits with diagnoses of severe sepsis with septic shock (an infection that has spread throughout the body and is life threatening), chronic kidney disease, morbid obesity, anticoagulant use (blood thinners), and Clostridium difficile. R68 required extensive assistance of two staff for bed mobility, toileting, and extensive assistance of one staff for personal hygiene. Transfers occurred once or twice during the assessment and required two staff. R68's Care Area Assessments (CAAs) dated 2/22/22, indicated R68 triggered for cognitive loss, urinary incontinence, psychosocial well-being, dehydration, and pressure ulcers. R68's progress note dated 3/27/22, at 4:08 p.m. indicated R68's stool sample was reported positive for C-Diff at 1:30 p.m. on 3/27/22. R68 was placed on contact precautions and advised to wash his hands using soap and water and not hand sanitizer. R120's admission MDS dated 3/19/22, indicated R120 was cognitively intact with diagnoses of urinary tract infection, acute respiratory failure with hypoxia (low oxygen), chronic kidney disease with a kidney transplant, and seizures. During a continuous observation and interviews on 3/28/22, from 12:36 p.m. to 12:50 p.m. an enteric transmission-based precautions (TBP)	F 880		

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sign was posted on the door to room 121 where R68 (window side) and R120 (door side) resided. The sign indicated everyone entering the room must: clean their hands with sanitizer and wear a gown and gloves and, upon exiting the room, everyone was to wash their hands with soap and water. Nursing assistant (NA)-E entered room 121 wearing a surgical mask, but no gown or gloves as indicated by the TBP sign. NA-E stated R68 was recently diagnosed with Clostridium difficile. NA-E stated, although the TBP sign indicated gowns and gloves were required upon entering the residents' room, NA-E was a student nurse and had learned they were only required when providing direct cares. Social worker (SW)-A then entered room 121 carrying a meal tray wearing a surgical mask and eye protection but no gown or gloves. SW-A placed R120's meal tray on his bedside table and positioned the table to the left side of his bed, towards R68's bed, to face the television. R68 was sitting in his wheelchair on the right side of his bed toward R120's bed, also facing the television. SW-A then wheeled R120 in his wheelchair, behind his bedtable to the left of his bed. R68 and R120 were now sitting next to each other facing the television, less than three feet apart. SW-A pushed the curtain divider between the two residents back far enough that R68 and R120 could view each other's meal trays, and legs but not their faces. SW-A stated R68 was on TBP but she did not know why. SW-A stated she used hand sanitizer when she left the room and gloves and gowns were only required when providing direct care such as toileting; not when pushing a resident in their wheelchair. SW-A stated she did not usually deliver resident meals and had not read the TBP sign prior to entering room 121. SW-A was unaware of the requirement to wash

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her hands upon exiting the room and asked if she was supposed to wash them in the residents' sink.

During a continuous observation and interview on 3/28/22, at 4:53 p.m. registered nurse (RN)-H stated R68 had been moved to a private room due to his recent diagnosis of C-Diff. A large, clear plastic bag of clothing was on R68's previous bed and the windowsill next to his bed was covered with personal items such as urinals, bedding, a dumbbell weight, and various lotions and bottles. The TBP sign had been removed from the door leaving no indication the room remained contaminated. RN-H stated anyone entering the room could become contaminated or infected and spread the bacteria if they handled R68's items and bedding without wearing proper personal protective equipment (PPE) such as gowns and gloves. At 5:18 p.m. RN-H entered R68's room without a gown or gloves and picked up R68's walker, gait belt, a grabber used to pick up items from the floor, and the large plastic bag of clothing from the bed and carried them down the hall to R68's new room. RN-H stated she should have worn a gown and gloves when touching R68's personal items as they could brush against her clothing and contaminate them. At 5:28 p.m. R68's personal items remained on the windowsill in R68's room with no indication the items were contaminated.

During an observation and interview on 3/29/22, at 11:42 a.m. nursing assistant (NA)-D came out of R68's new room carrying a gait belt and removing gloves from her hands. NA-D then balled the gloves in her hands while carrying the gait belt as she walked down the hallway. NA-D stated she had gone into R68's room to pick a

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towel up off the floor but had not worn gloves or a gown because the towel was clean, and she was not providing cares to R68. NA-D stated it had not occurred to her that the towel could have been contaminated.

During observation and interview on 3/29/22, at 1:10 p.m. R68's old room had been cleaned and the bed was made. The dumbbell previously seen, remained as the only item on the windowsill and a green sling used with a hydraulic lift when transferring resident from one surface to another such as a bed and toilet, hung on the bathroom door. Maintenance (MT)-A entered R68's room and explained he was going to be working on the window. MT-A then picked up the dumbbell and moved it out of his way on the windowsill. NA-E entered the room and confirmed the dumbbell and sling belonged to R68 and should have been brought to R68's new room the previous day. MT-A stated he was unaware the items belonged to R68 and were possibly contaminated.

During an interview on 3/31/22, at 11:28 a.m. the infection preventionist (IP) stated staff were to wear eye protection, masks, and gloves when entering a resident's room who is on enteric TBP for C-Diff. Staff should have used hand sanitizer before entering the room and donning gloves, remove and dispose of the gloves in the resident's room, and wash their hands in the resident sink prior to leaving the room. Staff were to wear gowns when providing direct care or contacting the environment of a resident on TBP or their roommate, including wheelchairs and bed tables. IP stated SW-A should have worn a gown and gloves when she assisted R120 and SW-A should have washed her hands prior to leaving R68's room to avoid cross-contamination. IP also

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AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(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 880	Continued From page 31 stated the dumbbell and sling should have been removed prior to R68's area being cleaned to avoid possible contamination. During an interview on 3/31/22, at 12:00 p.m. the interim director of nursing (DON) stated masks, eye protection, and gloves were to be worn prior to entering rooms of residents on TBP to avoid cross contamination of residents or staff who were not infected . The DON further stated the staff were to follow the facility policy. The facility Clostridium Difficile Infection (CDI) policy dated 10/26/21, indicated C-Diff spores could live on surfaces in the environment for months and staff could spread the bacteria through hand contact after touching a contaminated surface. Gloves were to be worn prior to entering a resident's room with known or suspected CDI and removed prior to exiting the room. Gowns were to be worn while providing direct care or when coming into contact with the resident's environment.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 32 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883		

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F 883	Continued From page 33 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an influenza vaccine was offered and provided to 1 of 5 residents (R27) reviewed for immunizations. Findings include: R27's Admission Record printed 3/31/22, indicated R27 was over 65 years old, and had been admitted to the facility on 1/6/22. R27's admission Minimum Data Set (MDS) dated 1/11/22, indicated R27 had not received the influenza vaccination upon admission and lacked any further information about influenza vaccination. R27's medical record lacked evidence that R27 was offered or received the influenza vaccine, nor education about the influenza vaccine. R27's Minnesota Immunization Information Connection (MIIC) report dated 3/30/22, indicated R27's last influenza vaccine was 11/1/18. On 3/30/22, at 12:00 p.m. the infection preventionist (IP) was interviewed and stated she has not assessed R27's eligibility for the influenza vaccine. The IP assessed R27's MIIC report during the interview, and stated R27 had not had an influenza vaccination this year. The IP stated R27 should have had an influenza vaccination upon admission. On 3/31/22, at 11:04 a.m. the acting assistant	F 883		

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F 883	Continued From page 34 directing of nursing (DON) was interviewed and stated she would expect the nurses to offer influenza vaccine upon admission, document education provided, or document refusal. The DON confirmed there was no evidence R27's influenza immunization status had been addressed or documented during admission. The Center for Disease Control and Prevention identified everyone 6 months and older are recommended to get an influenza vaccination annually, with rare exceptions. The facility's Influenza Vaccine policy revised 9/24/21, directed residents would be assessed for eligibility for the vaccine upon admission, educated about influenza vaccination, and offered the vaccine annually or upon admission as indicated.	F 883		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a tube feeding pump, pole and base was cleaned and in sanitary condition for 2 of 2 residents (R12 and R33) reviewed for tube feeding. Findings include: R12's significant change Minimum Data Set (MDS) dated 1/1/22, indicated R12 cognition was	F 921		

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F 921	Continued From page 35	F 921		

severely impaired. R12's diagnoses included protein-calorie malnutrition and dysphagia. R12 had a feeding tube and had 51% or more of total calories received through parenteral or tube feeding during the entire seven day look back period.

R33's quarterly MDS dated 1/18/22, indicated R33's cognition was severely impaired. R33's diagnoses included malnutrition and dysphagia. R33 had a feeding tube and had 51% or more of total calories received through parenteral or tube feeding during the entire seven day look back period.

During observation on 3/29/22, at 12:04 p.m. R12 was lying in bed. R12's tube feeding equipment had a moderate amount of dried tan colored substance present on the pump, the pole and the base of the pole.

During observation on 3/30/22, at 8:51 a.m. R12's tube feeding equipment was observed to continue to have the dried tan substance present on the pump, pole and base. R12's tube feeding pump wasn't running and was at the bedside. R12 had a container of tan colored liquid formula attached to the pump with the tubing hanging and the tip open to air with small amount of tan colored dried liquid in the tip

During observation on 3/29/22, at 12:06 p.m. R33 was lying in bed. R33's tube feeding equipment had a moderate amount of dried tan colored substance present on the pump, the pole and the base of the pole.

.During observation on 3/20/22, at 8:52 a.m. R33's tube feeding equipment was observed to

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F 921	Continued From page 36	F 921		

continue to have the dried tan substance present on the pump, pole and base. R33's tube feeding pump wasn't running and was at the bedside. R33 had a container of tan colored liquid formula attached to the pump with the tubing hanging and the tip open to air with small amount of tan colored dried liquid in the tip.

During interview on 3/30/22, at 10:33 a.m. registered nurse (RN)-A stated she was unaware of which staff members cleaned resident equipment. RN-A verified the current condition of R12's and R33's tube feeding equipment was unsanitary and looked like the dried formula had been on the equipment for a while.

During interview on 3/30/22, at 10:33 a.m. nursing assistant (NA)-A stated there wasn't a schedule for cleaning resident equipment. Further, NA-A stated resident equipment is cleaned when it is noticed to be "dirty". NA-A verified the current condition of R12's and R33's tube feeding equipment looked like the dried formula had been on the equipment for a while.

During interview on 3/30/22, at 10:37 a.m. registered nurse manager (RN)-C stated there wasn't a schedule for cleaning resident equipment and was unaware what staff members cleaned resident equipment. RN-C verified R12's and R33's tube feeding equipment was unsanitary and should have been cleaned.

Facility policy, Clean-disinfect equipment, last reviewed 10/26/21, indicated noncritical resident care items require low level of disinfection by cleaning periodically and after visible soiling.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 20, 2022

Administrator
Augustana HCC Of Apple Valley
14650 Garrett Avenue
Apple Valley, MN 55124

Re: State Nursing Home Licensing Orders
Event ID: F8UY11

Dear Administrator:

The above facility was surveyed on March 28, 2022 through March 31, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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	00979	A. BUILDING: _____ B. WING _____	03/31/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/28/22 to 3/31/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to promote comfort with poor wheelchair posture and worsening hemorrhoids for 1 of 2 residents (R39) reviewed for positioning and quality of care. In addition, the facility failed to ensure 1 of 1 resident (R472) had weights monitored in accordance with physician parameters to prevent complication of associated medical conditions. In addition, the facility failed to coordinate with an outside orthopedic clinic to adequately monitor a surgical wound to ensure healing and reduce the risk of complications for 1 of 1 residents (R375)	2 830		

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2 830	Continued From page 3 who admitted after surgery. Findings include: R39's quarterly Minimum Data Set (MDS), dated 1/19/22, identified R39 had intact cognition, used a wheelchair for mobility, and required supervision to completed most activities of daily living (ADLs). On 3/28/22, at 3:07 p.m. R39 was seated in a standard wheelchair in her room. R39 appeared to be slouched in the wheelchair with her buttocks positioned towards the front of the wheelchair cushion and her arms extended upward to rest on the provided wheelchair armrests. R39 was interviewed at this time and expressed she did not like her wheelchair as it was, "about 20 years old and falling apart." R39 stated she tried using a black cushion to help improve her positioning in the chair awhile back, and pointed to it stored against the wall and her cabinet; however, stated it did not help much. R39 stated she had never been screened or evaluated for her wheelchair positioning to her knowledge but added, "I wish they would." During subsequent observation on 3/29/22, at 11:55 a.m. R39 continued to use the same standard wheelchair and continued to appear slouched back with her arms having to be extended upward to rest on the provided arm rests. R39 denied any discomfort from sitting in such position at this time. R39's care plan, last revised 1/26/22, identified R39 used a manual wheelchair for mobility and was independent with it's use. The care plan lacked any dictation or documentation on R39's positioning while seated in the wheelchair or if	2 830		

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2 830	Continued From page 4 she had ever been evaluated by therapy for such; nor any information on the use of the black cushion present in R39's room which, according to R39, had been trialed in the past for her wheelchair positioning without success. When interviewed on 3/30/22 at 9:19 a.m., nursing assistant (NA)-C stated she had worked at the nursing home for "about a month" and had noticed R39 seemed to appear slouched in her wheelchair with her arms having to extend upward at the shoulder to rest on the armrests even when repositioned. NA-C described R39's posture as, "[she] shlumped back" in the chair and expressed R39's posture and positioning in the wheelchair had been such since she started working there. NA-C stated she was unaware of the black cushion present in R39's room and expressed she had never used it with R39 prior. Further, NA-C stated she had not reported any concerns about R39's posture in the wheelchair as R39 expressed she "is fine" with it and NA-C felt, overall, R39 "barely shlumps" while seated in the wheelchair. During interview on 3/30/22, at 9:58 a.m. NA-B expressed she had worked with R39 for several months and had noticed her positioning in the wheelchair was poor and caused R39's back to hunch back when she was seated in the device. NA-B stated she had even told R39 "you're not sitting right" several times before and added she was unaware of the black cushion, nor any use of it, in R39's room. Further, NA-B stated she was unsure if therapy had ever worked with R39 on wheelchair positioning in the past but added, "Not that I know of." R39's medical record was reviewed and lacked evidence R39 had been comprehensively	2 830		

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2 830	Continued From page 5 assessed or screened for her wheelchair positioning despite having a poor posture which had been observed by direct care staff for at least a month prior. On 3/30/22, at 10:30 a.m. registered nurse unit manager (RN)-D stated she had noticed R39 appeared "a little slouched" while seated in her wheelchair; however, had not worked with occupational therapy (OT) for this concern to her knowledge adding, "I don't think we've done any wheelchair mapping on her." RN-D expressed she was unaware of the black cushion in R39's room, nor when or how it was used, for R39's positioning in the past and voiced if staff were seeing concerns with R39's positioning they should bring those forward. Further, RN-D voiced it was important to ensure good wheelchair positioning was maintained as poor posture or positioning could be "a safety concern" and to reduce the risk of kyphosis (an abnormally curved spine) or other concern. When interviewed on 3/31/22, at 10:21 a.m., occupational therapist (OT)-A stated she had worked at the nursing home for "over a year" and R39 had not been evaluated for wheelchair positioning to her knowledge. OT-A stated any concerns with wheelchair positioning should be evaluated and the medical provider updated so orders for OT to evaluate them can be obtained. OT-A added it was important to ensure wheelchair positioning concerns were addressed timely as poor posture could lead to back pain and interventions could "get more complicated" the longer the issue is allowed. A facility' policy on wheelchair positioning was requested; however, none was received.	2 830		

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2 830	Continued From page 6 R39's quarterly Minimum Data Set (MDS), dated 1/19/22, identified R39 had intact cognition and required supervision to completed most activities of daily living (ADLs). On 3/28/22, at 3:03 p.m. R39 was interviewed and expressed she had hemorrhoids which seemed to be worsening and quite painful at times with increased bleeding noticed as of late. R39 stated she thought there was some medication she was taking for them; however, it was not routinely being given. When interviewed on 3/30/22, at 9:19 a.m. nursing assistant (NA)-C stated R39 had reported concerns to her about a month prior about her worsening hemorrhoids. R39 had expressed her buttocks "just hurt" because of them which caused NA-C to observe R39's rectum which exposed "a prolapsed hemorrhoid," so she reported the concern to the floor nurse who was working. Further, NA-C stated she was not aware of any medication being placed or given to help R39 with the issue and associated discomfort. R39's medical record was reviewed and lacked any evidence R39's worsening hemorrhoids had been assessed or interventions developed to reduce and/or eliminate them or the associated discomfort from them despite direct care staff having knowledge of the issue. On 3/30/22, at 10:30 a.m. registered nurse unit manager (RN)-D was interviewed and expressed she was unaware R39 had been having issues with her hemorrhoids. RN-D explained if a resident has such issues, then staff should report it so the nursing staff can go in to "check the area" and coordinate a treatment plan with the medical provider which could include the use of	2 830		

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2 830	Continued From page 7 Tuck Pads or other cream-based products. RN-D reviewed R39's Medication Administration Record (MAR) and verified there had been no treatments for R39's hemorrhoids in the past few months, nor was there any evidence in the medical record the issue had been assessed or addressed. RN-D stated the reported worsening hemorrhoids should have been addressed right away as the condition could worsen. A facility' provided Change In Condition policy, dated 2/2020, identified the nurse would notify the attending physician or on-call physicians with several scenarios listed including, " ... need to alter the resident's medical treatment significantly." However, prior to such notification, the policy directed, " ... the nurse will make detailed observations and gather relevant and pertinent information (complete SBAR; Situation Background Assessment and Response) for the provider." Adkins, Michelle R472's physician progress note printed 3/31/22, indicated R472 was admitted 3/23/22, with diagnoses of edema and chronic heart failure. R472's provider orders dated 3/23/22, indicated daily weights and a call to the provider for weight gain of more than 2 pounds per day, or 5 pounds per week. R472's weight log, medication administration record (MAR), and progress notes printed 3/31/22, indicated R472 was not weighed 2 of 8 days from 3/23/22, to 3/31/22. R472's care plan dated 3/23/22, indicated daily	2 830		

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2 830	Continued From page 8 weight and report increases in weight to provider greater than 2# in one day, or 5# in one week. When interviewed on 03/29/22, at 11:29 a.m. R472 stated her legs were swollen and she was supposed to have daily morning weights, but staff was not weighing her daily. R472 stated she was concerned about not getting daily weights because her torsemide (medication to reduce fluid retention) dosing depended upon her weight. Further, R472 indicated she was more short of breath while sitting which she stated was due to excess fluid. R472 stated she was not normally short of breath unless she was walking. When interviewed on 3/29/22, at 10:57 a.m. licensed practical nurse (LPN)-A stated the resident had an order for daily weights, and they had not been done as ordered. When interviewed on 3/30/22, at 8:25 a.m. registered nurse (RN)-F confirmed the weights were not recorded daily, and did not know why. When interviewed on 3/31/22, at 11:04 a.m. the acting director of nursing (DON) stated the expectation was that nursing assistants would get the daily weights as ordered, report them to the nurse, and the nurse would record them in the medical record. The DON stated the policy was to follow the orders as written, and if they were not, the resident could have fluid overload, heart complications, and increased edema. The facility's Weight Measurement policy revised 6/17/20, indicated weigh each resident monthly unless specifically ordered by physician to occur more often, and to record the weight in the electronic medical record.	2 830		

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2 830	Continued From page 9 Hoffman, Sherry R375's admission MDS dated 3/23/22, identified cognitively intact, did not reject cares, required extensive assistance for most activities of daily living (ADL's) had a knee replacement and required surgical wound care. R375's care plan dated 3/18/22, identified a surgical incision on right knee and directed staff to complete a body audit and weekly skin observation. Staff were also to monitor for signs of infection or not healing and were to update the provider as needed. R375's Physician Order Report dated 3/18/22, indicated R375 was to take doxycycline hyclate 100 mg every 12 hours; at 12:00 a.m. and 12:00 p.m. until 3/21/22, for the presence of an artificial knee joint. The orders also indicated to follow up with orthopedics as instructed, however, no instructions were included and no follow up was scheduled. R375's Visual Body Inspection dated 3/18/22, lacked any mention of R375's surgical incision. R375's Visual Body Inspection dated 3/24/22, lacked any mention of R375's surgical incision. R375's Comprehensive Skin Risk with Braden (a scale used to measure a resident's risk for pressure injuries) assessment dated 3/25/22, was incomplete and lacked a Braden score or any assessment or observation regarding R375's risk for pressure injury other than R375's need for assistance with ADLs. The "surgical wound" box	2 830		

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2 830	Continued From page 10 listed in section "Other Skin Concerns" was also left unmarked. R375's Physician Order Report indicated: -3/18/22, R375 was to follow up with orthopedics as instructed, however, no instructions were included. -3/21/22, Consult with onsite orthopedic nurse practitioner (NP)-A for a follow up regarding R375's right knee surgery, however, there was no evidence NP-A was not notified for a consult. R375's Physician Note dated 3/25/22, indicated R375 complained of pain and limited mobility to her right knee. The note also acknowledged R375 had not attended her previously scheduled follow up appointment with the orthopedic surgical team and that R375 did not believe it had been rescheduled. The note further indicated medical doctor (MD)-A would follow up with the surgeon regarding the removal of R375's surgical dressing since it had not been removed since the surgery on 3/9/22. During an interview and observation on 3/28/22, at 2:13 p.m. R375 stated she had a revision of her right total knee replacement on 3/9/22. R375 was discharged home after her surgery on 3/10/22. R375 had a follow up appointment with the surgical team scheduled for 3/22/22, however, on 3/16/22, she went to the emergency department due to extreme pain in her feet and ankles. R375 remained in the hospital for 2 days and was released to the facility for rehabilitation, on 3/18/22, with a diagnosis of gouty arthritis unrelated to her surgery. R375 stated after arriving at the facility, she looked at her online medical portal (MY Chart) to verify her follow up appointment but saw it had been canceled. R375 stated she had not canceled the appointment and	2 830		

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2 830	Continued From page 11 was not sure who had. R375 also stated, to her knowledge, the follow up appointment had not been rescheduled. R375 stated her surgical bandage was to remain on her right knee until the follow up appointment, however, since she never went to the appointment, the bandage was still on her knee and had not been removed or assessed by the facility staff. R375 was observed to have a white bandage approximately 6 inches long and 2 inches wide with clear adhesive over top that extended approximately one inch wider than the bandage on all sides, on her right knee. The bandage was intact and appeared clean and dry. The skin surrounding R375's bandage was extremely dry, white and flaky, but otherwise intact with no redness or swelling noted. No part of the surgical incision was visible under the bandage. R375's progress noted dated 3/28/22, at 9:51 p.m. indicated the dressing to R375's right knee was removed, and no redness, drainage, or signs of infection were noted. The incision was left open to air. During an interview on 3/29/22, at 11:32 a.m. R375 stated the surgical bandage had been removed by a nurse the previous evening. During an interview on 3/30/22, at 11:22 a.m. Twin City Orthopedics (TCO) care coordinator (CC-A) stated because R375's follow up appointment with the surgical team had been canceled, NP-A should have been notified and R375's surgical incision should have been assessed for signs of infection and dehiscence. CC-A further stated she wanted the staff to take a picture of R375's surgical incision and send it to the surgical team so they could assess it before R375 discharged home that afternoon.	2 830		

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2 830	Continued From page 12 During an interview on 3/30/22, at 12:18 p.m. Fairview surgical CC-B stated R375's follow up appointment on 3/22/22, would have been canceled by the facility because the post operative follow up is important and the surgical team would not have canceled it. During an interview on 3/30/22, at 8:57 a.m. facility physician's assistant (PA)-A stated when she saw R375 on 3/21/22, she did not assess R375's knee because the surgical bandage was still covering it. PA-A stated because R375 was discharged to her private home after surgery, many of R375's post-op and discharge orders were missed by the facility. PA-A stated if R375 had been admitted to the facility immediately after her knee surgery, R375 would have been assessed by the facility onsite orthopedic NP-A. However, because R375 came in with a diagnosis of gouty arthritis, those orders were missed. PA-A also stated she did not know who canceled R375's follow up appointment with the surgical team on 3/22/22. PA-A further stated she was unaware that R375's surgical dressing had not been removed and the incision site assessed until the evening of 3/28/22. PA-A stated there would have been concern that the incision could have dehisced (a complication causing the incision to separate and open) or become infected if it had not been assessed for almost three weeks after the surgery was performed. During an interview on 3/30/22, at 12:32 p.m. MD-A verified the order on 3/21/22, to consult with NP-A. MD-A did not know why that was not done and the facility should have followed up on it. MD- A also stated she had seen R375 on 3/25/22, and noted the surgical dressing from 3/9/22, was still on R375's right knee.	2 830		

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2 830	Continued From page 13 The facility Skin Integrity policy dated 2/4/21, indicated licensed staff would perform a head-to-toe inspection of their skin upon admission to the facility and document their findings in the resident's electronic medical record (EMR). The care plan and interventions to treat existing skin concerns would be implemented based on the resident's skin risk assessment and communicated to the nursing assistants (NAs) via assignment sheets. Licensed staff were to complete a head-to-toe assessment of the resident's skin and document findings in the EMR. NAs were to perform daily skin checks during routine cares and report concerns a licensed nurse. Resident skin alterations were to be documented in the EMR and include the alteration's location, a description of the skin, up to 4 centimeters (cm), surrounding the wound. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could review and /or revise policies and procedures to ensure timely assessment and treatment of developed medical conditions and/or wheelchair positioning. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		

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21375	Continued From page 14 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure staff wore appropriate personal protective equipment (PPE) and performed hand hygiene for 2 of 2 residents (R68, R120) on enteric, contact precautions for Clostridium difficile (C-Diff-an infection of the large intestine caused by long-term antibiotic use that can be serious and life threatening, that is highly contagious). This had the potential to effect all 19 residents on the unit being cared for by the same staff. Findings include: R68's admission Minimum Data Set (MDS) dated 2/22/22, indicated R68 had moderate cognitive deficits with diagnoses of severe sepsis with septic shock (an infection that has spread throughout the body and is life threatening), chronic kidney disease, morbid obesity, anticoagulant use (blood thinners), and Clostridium difficile. R68 required extensive assistance of two staff for bed mobility, toileting, and extensive assistance of one staff for personal hygiene. Transfers occurred once or twice during the assessment and required two staff. R68's Care Area Assessments (CAAs) dated 2/22/22, indicated R68 triggered for cognitive loss, urinary incontinence, psychosocial well-being, dehydration, and pressure ulcers.	21375		

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R68's progress note dated 3/27/22, at 4:08 p.m. indicated R68's stool sample was reported positive for C-Diff at 1:30 p.m. on 3/27/22. R68 was placed on contact precautions and advised to wash his hands using soap and water and not hand sanitizer.

R120's admission MDS dated 3/19/22, indicated R120 was cognitively intact with diagnoses of urinary tract infection, acute respiratory failure with hypoxia (low oxygen), chronic kidney disease with a kidney transplant, and seizures.

During a continuous observation and interviews on 3/28/22, from 12:36 p.m. to 12:50 p.m. an enteric transmission-based precautions (TBP) sign was posted on the door to room 121 where R68 (window side) and R120 (door side) resided. The sign indicated everyone entering the room must: clean their hands with sanitizer and wear a gown and gloves and, upon exiting the room, everyone was to wash their hands with soap and water. Nursing assistant (NA)-E entered room 121 wearing a surgical mask, but no gown or gloves as indicated by the TBP sign. NA-E stated R68 was recently diagnosed with Clostridium difficile. NA-E stated, although the TBP sign indicated gowns and gloves were required upon entering the residents' room, NA-E was a student nurse and had learned they were only required when providing direct cares. Social worker (SW)-A then entered room 121 carrying a meal tray wearing a surgical mask and eye protection but no gown or gloves. SW-A placed R120's meal tray on his bedside table and positioned the table to the left side of his bed, towards R68's bed, to face the television. R68 was sitting in his wheelchair on the right side of his bed toward R120's bed, also facing the television. SW-A then wheeled R120 in his wheelchair, behind his

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bedtable to the left of his bed. R68 and R120 were now sitting next to each other facing the television, less than three feet apart. SW-A pushed the curtain divider between the two residents back far enough that R68 and R120 could view each other's meal trays, and legs but not their faces. SW-A stated R68 was on TBP but she did not know why. SW-A stated she used hand sanitizer when she left the room and gloves and gowns were only required when providing direct care such as toileting; not when pushing a resident in their wheelchair. SW-A stated she did not usually deliver resident meals and had not read the TBP sign prior to entering room 121. SW-A was unaware of the requirement to wash her hands upon exiting the room and asked if she was supposed to wash them in the residents' sink.

During a continuous observation and interview on 3/28/22, at 4:53 p.m. registered nurse (RN)-H stated R68 had been moved to a private room due to his recent diagnosis of C-Diff. A large, clear plastic bag of clothing was on R68's previous bed and the windowsill next to his bed was covered with personal items such as urinals, bedding, a dumbbell weight, and various lotions and bottles. The TBP sign had been removed from the door leaving no indication the room remained contaminated. RN-H stated anyone entering the room could become contaminated or infected and spread the bacteria if they handled R68's items and bedding without wearing proper personal protective equipment (PPE) such as gowns and gloves. At 5:18 p.m. RN-H entered R68's room without a gown or gloves and picked up R68's walker, gait belt, a grabber used to pick up items from the floor, and the large plastic bag of clothing from the bed and carried them down the hall to R68's new room. RN-H stated she

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should have worn a gown and gloves when touching R68's personal items as they could brush against her clothing and contaminate them. At 5:28 p.m. R68's personal items remained on the windowsill in R68's room with no indication the items were contaminated.

During an observation and interview on 3/29/22, at 11:42 a.m. nursing assistant (NA)-D came out of R68's new room carrying a gait belt and removing gloves from her hands. NA-D then balled the gloves in her hands while carrying the gait belt as she walked down the hallway. NA-D stated she had gone into R68's room to pick a towel up off the floor but had not worn gloves or a gown because the towel was clean, and she was not providing cares to R68. NA-D stated it had not occurred to her that the towel could have been contaminated.

During observation and interview on 3/29/22, at 1:10 p.m. R68's old room had been cleaned and the bed was made. The dumbbell previously seen, remained as the only item on the windowsill and a green sling used with a hydraulic lift when transferring resident from one surface to another such as a bed and toilet, hung on the bathroom door. Maintenance (MT)-A entered R68's room and explained he was going to be working on the window. MT-A then picked up the dumbbell and moved it out of his way on the windowsill. NA-E entered the room and confirmed the dumbbell and sling belonged to R68 and should have been brought to R68's new room the previous day. MT-A stated he was unaware the items belonged to R68 and were possibly contaminated.

During an interview on 3/31/22, at 11:28 a.m. the infection preventionist (IP) stated staff were to wear eye protection, masks, and gloves when

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entering a resident's room who is on enteric TBP for C-Diff. Staff should have used hand sanitizer before entering the room and donning gloves, remove and dispose of the gloves in the resident's room, and wash their hands in the resident sink prior to leaving the room. Staff were to wear gowns when providing direct care or contacting the environment of a resident on TBP or their roommate, including wheelchairs and bed tables. IP stated SW-A should have worn a gown and gloves when she assisted R120 and SW-A should have washed her hands prior to leaving R68's room to avoid cross-contamination. IP also stated the dumbbell and sling should have been removed prior to R68's area being cleaned to avoid possible contamination.

During an interview on 3/31/22, at 12:00 p.m. the interim director of nursing (DON) stated masks, eye protection, and gloves were to be worn prior to entering rooms of residents on TBP to avoid cross contamination of residents or staff who were not infected . The DON further stated the staff were to follow the facility policy.

The facility Clostridium Difficile Infection (CDI) policy dated 10/26/21, indicated C-Diff spores could live on surfaces in the environment for months and staff could spread the bacteria through hand contact after touching a contaminated surface. Gloves were to be worn prior to entering a resident's room with known or suspected CDI and removed prior to exiting the room. Gowns were to be worn while providing direct care or when coming into contact with the resident's environment.

SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could

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	00979	A. BUILDING: _____ B. WING _____	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 19 review applicable policies and procedures to ensure proper donning and doffing of PPE for developed medical conditions and/or infectious disease care. The DON or designee could also review applicable policies and procedures to ensure the timely administration of recommended vaccinations for the resident population. They could then educate the direct care staff on these polices and develop and/or implement monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a tube feeding pump, pole and base was cleaned and in sanitary condition for 2 of 2 residents (R12 and R33) reviewed for tube feeding. Findings include: R12's significant change Minimum Data Set (MDS) dated 1/1/22, indicated R12 cognition was severely impaired. R12's diagnoses included protein-calorie malnutrition and dysphagia. R12 had a feeding tube and had 51% or more of total	21665		

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21665	Continued From page 20 calories received through parenteral or tube feeding during the entire seven day look back period. R33's quarterly MDS dated 1/18/22, indicated R33's cognition was severely impaired. R33's diagnoses included malnutrition and dysphagia. R33 had a feeding tube and had 51% or more of total calories received through parenteral or tube feeding during the entire seven day look back period. During observation on 3/29/22, at 12:04 p.m. R12 was lying in bed. R12's tube feeding equipment had a moderate amount of dried tan colored substance present on the pump, the pole and the base of the pole. During observation on 3/30/22, at 8:51 a.m. R12's tube feeding equipment was observed to continue to have the dried tan substance present on the pump, pole and base. R12's tube feeding pump wasn't running and was at the bedside. R12 had a container of tan colored liquid formula attached to the pump with the tubing hanging and the tip open to air with small amount of tan colored dried liquid in the tip During observation on 3/29/22, at 12:06 p.m. R33 was lying in bed. R33's tube feeding equipment had a moderate amount of dried tan colored substance present on the pump, the pole and the base of the pole. .During observation on 3/20/22, at 8:52 a.m. R33's tube feeding equipment was observed to continue to have the dried tan substance present on the pump, pole and base. R33's tube feeding pump wasn't running and was at the bedside. R33 had a container of tan colored liquid formula	21665		

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21665	Continued From page 21 attached to the pump with the tubing hanging and the tip open to air with small amount of tan colored dried liquid in the tip. During interview on 3/30/22, at 10:33 a.m. registered nurse (RN)-A stated she was unaware of which staff members cleaned resident equipment. RN-A verified the current condition of R12's and R33's tube feeding equipment was unsanitary and looked like the dried formula had been on the equipment for a while. During interview on 3/30/22, at 10:33 a.m. nursing assistant (NA)-A stated there wasn't a schedule for cleaning resident equipment. Further, NA-A stated resident equipment is cleaned when it is noticed to be "dirty". NA-A verified the current condition of R12's and R33's tube feeding equipment looked like the dried formula had been on the equipment for a while. During interview on 3/30/22, at 10:37 a.m. registered nurse manager (RN)-C stated there wasn't a schedule for cleaning resident equipment and was unaware what staff members cleaned resident equipment. RN-C verified R12's and R33's tube feeding equipment was unsanitary and should have been cleaned. Facility policy, Clean-disinfect equipment, last reviewed 10/26/21, indicated noncritical resident care items require low level of disinfection by cleaning periodically and after visible soiling. SUGGESTED METHODS OF CORRECTION: The director of nursing or designee could review applicable policies and procedures on the timely and routine cleaning of resident care equipment;	21665		

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21665	Continued From page 22 then educate staff and develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		

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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 03/30/2022. At the time of this survey, AUGUSTANA HEALTHCARE CENTER OF APPLE VALLEY 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

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 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. AUGUSTANA HEALTHCARE CENTER OF APPLE VALLEY is a three-story building, with a full basement The building was constructed in 1983 and was determined to be of Type II (222) construction, with a full basement. The building is protected by a full fire sprinkler	K 000		

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K 000	Continued From page 2 system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 178 beds and had a census of 102 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=E	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	K 324		

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper protection from hazards in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5, 19.3.2.5.3(9). These deficient findings could have a patterned impact on the residents within the facility. Findings Include: 1. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation that in the lower-level of the facility in the Occupational Therapy Room there was residential stove. No electrical disconnect or lock-out device was observed in the immediate area of the stove. 2. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation that in the lower-level of the facility in the Therapy Recreational Room there was residential stove. No electrical disconnect or lock-out device was observed in the immediate area of the stove. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324		
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 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		

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K 353	Continued From page 4 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 9.7.5, 9.7.7, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1, 5.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that a fire sprinkler system quarterly inspection had been conducted or completed for 4th quarter 2021. 2. On 03/30/2022 between 09:30 AM to 02:30	K 353		

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K 353	Continued From page 5 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that a fire sprinkler system 5 year inspection had been completed since 2016. (The year 2016 was observed on the 3rd floor fire sprinkler riser gage, and the full date of 10/05/2016 was observed on the fire sprinkler riser gage located in the basement of the facility.) 3. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation that on the 3rd floor - Dining Room - Mechanical Room, cabling was attached to the fire sprinkler system piping. 4. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation that on the 2rd floor in RM E-205, cabling was found attached to the fire sprinkler system piping. 5. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation that on the 2rd floor in E corridor above the ceiling that cabling was found attached to the fire sprinkler system piping. 6. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation that on the Lower Level in the Boiler Room, cabling was found attached to the fire sprinkler system piping. 7. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation that on the 1st floor - East corridor, cabling was attached to the fire sprinkler system piping. 8. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the 2nd	K 353		

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K 353	Continued From page 6 floor in the Dining Room Area that fire sprinkler heads in the vicinity of the serving kitchen were covered with a foreign substance. 9. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the Lower Level in the Laundry Washing and Dryer Areas, that fire sprinkler heads exhibited signs of oxidation. 10. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation on the Lower Level in the Kitchen Dishwashing Area that fire sprinkler heads exhibited signs of oxidation. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire 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. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the NFPA 101 (2012 edition),	K 712		

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K 712	Continued From page 7 Life Safety Code, sections 19.7.1.4, 19.7.1.6, 4.7.2, and 4.7.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that a fire drill had been conducted for 2nd shift - 3rd quarter 2021 2. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed during documentation review that the that fire drill reports presented for review revealed a lack of randomness in the calendar dates on which drills were conducted. a. 1st shift - 1st and 2rd quarter drills were conducted on the same calendar date - 31st b. 1st shift - 3rd and 4th quarter drills were conducted on the same calendar date - 30th c. 11 of 12 documented fire drills were conducted in the last week of each respective quarter An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712		
K 914 SS=C	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional	K 914		

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K 914	Continued From page 8 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 1 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 record information associated to electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4.1.4, 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by a review of available documentation that the documentation presented for review did not identify who completed the inspections of resident rooms and the dates on which they were completed. An interview with the Maintenance Director and Administrator verified this deficient finding at the	K 914		

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K 914	Continued From page 9 time of discovery.	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918		

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	245264	A. BUILDING **01** B. WING _____	**03/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to maintain the emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.13, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1, 8.3, 5.6.5.6, 5.6.6, 5.6.5.2(4), NFPA 70 (2011 edition), National Electrical Code, sections 110.1, 110.26, 110.26(A)(1), 110.26(C)(1). These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility, that the generator emergency stop was located on an electrical panel in mechanical room. Access to the generator emergency stop was fully obstructed at the time of inspection. 2. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by a review of the most recent vendor annual on-site inspection report (Cummins 03/15/2021), that the technician noted the battery age was at that time in excess of 2 years. 3. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that the generator remote annunciator panel located in the area of the 1st floor Nursed Station did not function or illuminate upon testing. It could not be confirmed that the generator remote annunciator panel was operational	K 918		

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K 918	Continued From page 11 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation and usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and	K 920		

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K 920	Continued From page 12 NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that an extension cord was in use on the 3rd floor in Room N-337 2. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that appliances were connected to power strips in the following locations: 3rd floor in Room E-305; 2nd floor in the Dining Room; 2nd floor in S-228; Lower Level in the Payroll Office; Lower Level in the Admin Office 3. On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that power strips were daisy-chained together on the Lower Level in Office S-1 An interview with the Maintenance Director verified these findings at the time of discovery.	K 920		
K 923 SS=C	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	K 923		

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K 923	Continued From page 13 limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored 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 5.1.3.3.2(2), 5.1.3.3.4, 5.1.3.3.4.1, 11.3, 11.3.2, 11.3.2.3, 11.3.4, 11.6.2, 11.6.2.3(3), 11.6.5, NFPA 55 (2010 edition), Compressed Gases and Cryogenic Fluids Code, sections 7.1.4.2.1, 7.1.8.4, 7.1.8.1, 7.1.8.2. This deficient finding	K 923		

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K 923	Continued From page 14 could have a patterned impact on the residents within the facility. Findings include: On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by observation that 3rd floor - N-329 and 2nd floor N-229, Med Gas Rooms were found unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 923		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based a review of available documentation review and staff interview, the facility failed to provide information related to onboard training and annual refresher training as medical gas and equipment as it related to NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 926		

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K 926	Continued From page 15 On 03/30/2022 between 09:30 AM to 02:30 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that the facility has in place a medical gas (O2) training program for the onboarding of new staff and annual refresher training for current staff. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 926		