Electronically delivered
October 17, 2022

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: September 29, 2022

Dear Administrator:

On September 29, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 29, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 29, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601

(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 9/26/22, to 9/29/22, 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 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their	E 037		11/10/22

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

Electronically Signed | 10/26/2022

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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E 037	Continued From page 1 expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:	E 037		

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E 037	Continued From page 2 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:	E 037		

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E 037	Continued From page 3 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 4 policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 3 employees (RN-C, NA-F) had received annual training on the emergency preparedness plan. This had the potential to affect all 59 residents residing in the facility.	E 037	1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice? a.All staff have been assigned online emergency preparedness training and all staff will receive in-person education on	

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E 037	Continued From page 5 Findings include: On 9/28/22, at 1:35 p.m. a review of the facility's emergency preparedness program review was completed with manager of facility operations (MFO)-A. MFO-A stated the employees were expected to complete annual emergency preparedness training. During an interview on 9/29/22, at 9:55 a.m. director of nursing (DON) provided Completed Training records for three employees and confirmed registered nurse (RN)-C and nursing assistant (NA)-F had not completed emergency preparedness training annually. DON identified the emergency preparedness training had not been assigned as required for some of the facility's employees. Review of RN-C's Completed Training form identified RN-C's Emergency Preparedness Basics education was completed on 8/7/19, three years prior to the start of the recertifcation survey. Review of NA-F's Completed Training form identified NA-F's Emergency Preparedness Basics education was completed on 12/6/18, three years and 10 months prior to the start of recertification survey. The facility policy titled Training And Testing Plan, undated, identified annual training of all staff, volunteers, contract or agency, and as needed (PRN) training would occur. The policy indicated the annual education would have been conducted through formal training sessions, in-service, etc. The policy indicated the annual training must have been documented.	E 037	11/1 or 11/2. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. a.All residents have the potential to be affected by this. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a.Annual online training for emergency preparedness was assigned to all staff in April and is on the training calendar annually. This is reflected on the annual training calendar in subsequent years. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a.Once in-person training is completed at all-staff in services on 11/1 and 11/2 emergency preparedness coordinator will review training compliance with departmental leaders until all active employees have completed training or makeup education. After all current staff are trained, emergency preparedness coordinator or designee will audit all nursing home staff to ensure emergency preparedness education is up to date. This will occur until compliance has been maintained for three consecutive months. This will be monitored by quality assurance committee	

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F 000	Continued From page 6	F 000		
F 000	INITIAL COMMENTS On 9/26/22, to 9/29/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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 following complaints were found to be UNSUBSTANTIATED: H50391688C (MN83481), H50394712C (MN84664), H50394711C (MN86092), H50394798C (MN85622). 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 677	1. How corrective action will be	11/10/22

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F 677	Continued From page 7 review, the facility failed to provide oral cares for 1 of 1 resident (R34) who was dependent on staff and reviewed for activities of daily living (ADL's.) Findings include: R34's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 9/1/22, revealed R34 had diagnoses which included Alzheimer's disease, paranoid schizophrenia, and drug induced dyskinesia (uncontrolled, involuntary muscle movement, such as with the mouth.) The MDS indicated R34 had severe cognitive impairment, required extensive assistance with eating and was dependent on staff for dressing, personal hygiene and bathing. The MDS identified R34 had difficulty making herself understood and had difficulty understanding others. The MDS revealed R34 received hospice care and had a terminal prognosis (less than six months to live.) R34's SCSA Care Area Assessment (CAA) dated 9/1/22, identified R34 received hospice services, was not able to communicate her needs, and required assistance with ADL's. The CAA revealed R34 had severe cognitive impairment and required staff to anticipate her needs. R34's care plan revised 9/6/22, revealed R34 required assistance with ADL's of dressing, grooming and bathing. The care plan indicated R34 required assistance with oral cares daily and as needed. On 9/26/22, at 6:44 p.m. R34 was observed lying in bed on her back and she was covered with a blanket from her feet to her chest. R34's eyes were closed, her mouth was open and revealed	F 677	accomplished for those residents found to have been affected by the deficient practice. a.Oral cares were provided to resident R34 on 9/29/2022 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. a.Facility will review care plans of all dependent residents and will create a list of those residents who are dependent for oral cares. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a.All nursing staff will be educated on Denture and Oral Care, Dental Health Assessment, Dental Services policy on 11/1 or 11/2 by the director of Nursing Services (DNS). 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a.Director of Nursing Services or designee will conduct Audits on oral care for Five residents weekly times 4 weeks, bi-weekly x2, monthly x3 and then quarterly until QAPI committee has determined compliance sustained. . These audits will occur weekly for 4 weeks and then will happen every other week for 2 months. Audit findings will be reported to the quality assurance committee.	

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F 677	Continued From page 8	F 677		

dry mucosa with white sticky matter on her tongue, around her teeth and her lips. R34 made a chewing motion with her mouth (dyskinesia), her lips stuck together when closed and peeled away when re-opened. R34 moved her tongue out towards her lips, stuck to her lower lip and she moved her tongue back in her mouth. A sign was posted on R34's wall above her bed dated 7/21, which revealed a note to offer fluids with cares.

On 9/27/22, at 8:27 a.m. R34 was observed lying in bed on her back, her mouth was opened to reveal dry oral mucosa, flakes of skin along her lips, and white, thick, pea sized particles were in her mouth along her gums, inner cheeks and tongue.

-at 3:45 p.m. R34 was observed lying in bed on her back and she was covered with a blanket from her feet to her upper chest. R34's eyes were closed, her mouth was open and revealed dry mucosa with white sticky matter on her tongue, around her teeth and her lips

On 9/28/22, at 7:10 a.m. R34 was observed lying in bed on her back, her mouth was opened, her lips and mouth had flaking skin.

-at 8:15 a.m. R43 remained lying in bed on her back and she was covered with a blanket from her feet to her chest. R34's mouth was open, she had dry flaky skin around her lips and and white, thick, pea sized particles were in her mouth along her gums, inner cheeks and tongue.

On 9/28/22, at 9:37 a.m. during an observation, R34 was lying on her back in bed, her mouth was open and revealed dry oral mucosa, dry flaky skin

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F 677	Continued From page 9 around her lips and her tongue had grooves along the length of her tongue. At that time, nursing assistants (NA)-C and NA-E entered R34's room and proceeded to assist her with a mechanical lift out of bed, into her wheelchair. NA-E assisted R34 with braiding her hair and indicated she would get her something to drink. NA-C then proceeded to wheel R34 out of her room, towards the dining room. R34 was not observed to be offered or provided oral cares. During an interview on 9/28/22, at 2:31 p.m. NA-C indicated R34 was totally dependent for all ADL's which included dressing, transfers and bathing. NA-C indicated R34 was not able to verbalize her needs and her needs were to be anticipated. NA-C stated R34 required assistance with oral cares and should have her mouth swabbed out with toothettes (foam stick applicator used to provide oral cares) with cares. NA-C confirmed he had not provided oral cares for R34 with her morning cares. During an interview on 9/28/22, at 3:00 p.m. NA-E stated R34 was not able to verbalize her needs and was dependent on staff for her ADL's, which included oral cares. NA-E confirmed she had not provided oral cares or offered oral cares to R34 when she assisted her up earlier that morning. NA-E indicated R34's mouth was routinely dry and required routine moisturizing and cleansing. During an interview on 9/29/22, at 10:15 a.m. clinical nurse manager (CM)-A stated she expected R34 to have oral cares completed at least twice daily. CM-A stated she would expect staff to routinely swab R34's mouth with a toothette to remove any debris and to moisten her mouth as needed.	F 677		

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F 677	Continued From page 10 During an interview on 9/29/22, at 10:46 a.m. the director of nursing (DON) stated she would expect R34's oral cares to be offered and provided daily and would expect her mouth would be routinely swabbed to prevent dryness. Review of a facility policy titled Denture and Oral Care, Dental Health Assessment, Dental Services, revised 5/26/22, revealed it was the purpose of the policy to ensure good oral hygiene, and to provide comfort and well-being. The policy revealed procedures for providing oral cares to residents which included using a foam stick (toothettes) applicator moistened with water or mouth wash mixture to wipe gums, teeth, tongue, and inside the roof of mouth.	F 677		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an as needed analgesic to ensure routine pain management for 1 of 1 resident (R104) who reported severe pain without timely relief. Findings include: R104's admission Minimum Data Set (MDS) dated 9/22/22, identified R104 had diagnoses	F 697	1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Resident R104 received pain medication with relief of symptoms on 9/28. Resident has been in the hospital since 10/18, upon readmission to facility a comprehensive pain evaluation and evaluation of nonpharmacological	11/10/22

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F 697	Continued From page 11 which included quadriplegia, anxiety and depression. The MDS identified R104 was cognitively intact and required extensive assistance with activities of daily living (ADL's) of bed mobility, dressing, toileting and personal hygiene. The MDS revealed R104 received scheduled and as needed pain relieving medications during the look back period. The MDS identified R104 had no reports of pain in the last seven days. Further, the MDS identified R104 had received opioid medication (pain relieving medication) seven of seven days during the look back period. R104's admission Care Area Assessment (CAA) dated 9/22/22, identified R104 had diagnoses of quadripareses (quadriplegia), history of polysubstance abuse and required assistance with ADL's. The CAA lacked any information R104 had pain or was receiving any type of pain management. Review of R104's current care plan dated 9/22/22, revealed R104 had pain due to quadriplegia, required narcotic analgesic and received hydrocodone (narcotic pain relieving medication) as needed. The care plan indicated R104 was encouraged to request pain medication before his pain became unbearable and was to have pain medications offered prior to activities. The care plan revealed other medications such as baclofen (medication used to decrease muscle spasms) gabapentin (medication used to help with nerve pain) and ibuprofen (medication used to decrease inflammation) were to be administered and their effectiveness assessed. Review of R104's physician orders undated, revealed the following orders:	F 697	interventions will occur to best address his pain. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. a. All residents with a care plan for pain have the potential to be affected by this deficient practice. These care plans will be reviewed to ensure accuracy and appropriate pain interventions 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. DNS or designee will train all staff on verbal and non-verbal signs of pain, along with interventions both pharmacological and non-pharmacological. All staff administering pain medications will be trained on pain management policy and pain management observation tool. All residents with a care plan for pain will be reviewed weekly using the pain management observation tool. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a.5 residents at high risk for pain will be identified for each round of audits. DNS or designee will interview these residents regarding their pain management. These interviews will occur weekly for 4 weeks, bi-weekly x2, monthly x3 and quarterly until QAPI committee determines compliance has been achieved.	

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F 697	Continued From page 12 -acetaminophen tablet; 325 milligrams (mg), 650 mg by mouth, for mild pain, moderate pain every six (6) hours. -hydrocodone-acetaminophen - tablet; 5-325 mg, one tablet by mouth for severe pain every eight (8) hours. -baclofen tablet; 10 mg three times daily at 9:00 a.m., 4:00 p.m. and 9:00 p.m., started 9/21/22. Review of R104's September Medication Administration record from 9/16/22, to 9/28/22, revealed R104 received as needed hydrocodone-acetaminophen at least once daily with varying effectiveness of effective, somewhat effective and not effective. During an observation on 9/26/22, at 6:11 p.m. R104 was lying in bed, on his back, his eyes were shut tightly, his jaw was clenched tightly while he made a low groaning sound. R104 opened his eyes, and indicated he was having strong pain from spasms and had requested pain medication. R104 indicated he oftentimes waited a long time for the nurse to give him his medications for pain. R104 indicated, the pain would become severe before he received any medication. At 6:20 p.m. R104 received a hydrocodone and a mediation for anxiety. During an observation on 9/27/22, at 10:09 a.m. R104 was observed lying on his back in bed and he was covered with a white sheet from his feet to his abdomen. At that time, R104 stated he was in severe pain, was not able to visit. R104's eyes and jaw were clenched, his breathing was labored and his lower body was making twitching, jerking movements when his legs spasmed. During an interview on 9/28/22, at 7:07 a.m. R104	F 697		

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F 697	Continued From page 13 stated he was in significant pain, his legs were jumping from spasms. R104 stated he had regular leg spasms from his paralysis and indicated they could become extremely painful. He stated he received a few different medications for pain, such as baclofen and hydrocodone. R104 stated he felt the baclofen worked the best for pain, though indicated the hydrocodone worked well for breakthrough pain from the spasms. R104 stated he routinely had to wait for his pain medication when he asked, and felt if he received the medication timely, his pain would not escalate to a severe level. R104 indicated he had pain daily which interfered with his sleep and made it difficult to stay comfortable. He stated the facility recently increased his baclofen dosage, though stated he used to take it more frequently at four times a day vs the current three times a day. R104 stated he did not feel his pain was managed when he had to wait a long time, such as 30 minutes, for pain medications. Further, R104 stated he was not aware of any non-pharmacological interventions the staff offered for pain relief. On 9/28/22, during continuous observation from 7:12 a.m. to 8:27 a.m. the following was observed: -at 7:12 a.m. R104 was lying in his bed on his back, his lower body was covered with a sheet, his eyes were closed. R104 was whimpering, his lower body was twitching which would jerk his upper body in the opposite movement. At that time, R104 placed his call light on. -at 7:14 a.m. R104 remained lying in bed, his eyes opened, he was whimpering and groaning when his lower body twitched with spasms.	F 697		

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F 697	Continued From page 14 -at 7:17 a.m. R104 remained lying in bed, his eyes were opened, he continued to groan and whimper, his hands and jaw were clenched. -at 7:18 a.m. R104 remained lying in bed, his call light remained on, his eyes were open, he was whimpering and groaning. At that time, NA-D entered his room, took his water mug off of his over the bed table, and exited his room. -at 7:19 a.m. R104 remained lying in his bed on his back, he continued to whimper and groan. At that time, NA-D re-entered R104's room with the water mug full of ice water, placed the water on his over the bed table, and turned to leave the room. R104 asked NA-D to stop and told her he was in pain and requested pain medication. NA-D indicated she would let the nurse know and then proceeded to turn off R104's call light. NA-D was observed to walk up to the nurses station and informed licensed practical nurse (LPN)-A R104 requested pain medication and walked away. LPN-A was not observed to move from her position at the nurses station. -at 7:32 a.m. R104 remained lying in bed on his back, his jaw was tightened, brow furrowed, he continued to moan and groan, his lower body repeatedly jerked/twitched when his legs spasmed. -at 7:42 a.m. R104 remained lying in bed on his back, his eyes were closed, his jaw was clenched tightly, brows were furrowed, he could be heard moaning and groaning from the hallway adjacent to his room. R104's lower body continued to twitch and jerk from repeated leg spasms. At that time, LPN-A walked past his room, made no	F 697		

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F 697	Continued From page 15 attempt to answer his call light or made any indication she heard him moaning and groaning. -at 7:50 a.m. R104 remained lying on his back, he continued to make low guttural groaning sounds while his lower body was jerking in sudden movements. R104 repeatedly moaned which could be heard from the hallway adjacent to his room. At that time, clinical nurse manager (CM)-A walked past R104's room, made no indication she heard him and was not observed to enter his room. -at 7:54 a.m. R104 remained lying on his back, he continued moaning and groaning, and cried out in pain and his lower body was wracked with twitching movements. At that time, LPN-A was observed to leave a room near R104's, she walked past his room and made no indication she heard his moans. - at 8:03 a.m. R104 remained lying in bed, he continued to moan and groan, the pitch and frequency of the sounds increased with less rest in between. R104's eyes were shut, his jaw was clenched and his lower body jerked with spastic movements. R104 cried out when his lower body abruptly jerked. -at 8:08 a.m. R104 remained in bed on his back, he turned on his call light, as his room number displayed on the marquee above the nurses station. R104 continued moaning and groaning. -at 8:12 a.m. R104 remained lying in bed on his back, consistently moaning and groaning. At that time, LPN-A walked out of another residents room, kiddy corner from R104's room. She made no attempt to answer his call light and made no	F 697		

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F 697	Continued From page 16	F 697		

indication she heard R104's moaning and groaning.

-at 8:19 a.m. R104 remained lying on his back, consistently moaning and groaning with his jaw clenched tightly. R104's lower body jerked with spastic movements, his call light remained on.

-at 8:23 a.m. R104 remained on his back, at that time, NA-E entered R104's room walked over to his left side, offered to reposition him. R104 stated he was in pain and requested pain medication. NA-E indicated she would reposition him and would then get the nurse with his medication. R104's eyes were closed tightly, his jaw was clenched he nodded his head in agreement. NA-E helped R104 tilt to his right side, NA-E abruptly yanked a pillow out from underneath R104's back. R104 gasped, made a deep, low guttural groan and reached for the grab bar on the right side of his bed. At that time, NA-C entered his room and both NA-E and NA-C proceeded to assist R104 to position on his right side. R104 was observed to loudly moan and groan with each movement, while reporting pain to both NA's. R104's lower body consistently jerked with spastic movements, which he cried out in pain with each spasm. At that time, NA-E asked R104 what level his pain was, he indicated it was an eight (8) on a numeric pain scale (0-10, 0 no pain, 10 worst pain imaginable.) NA-E then proceeded to walk to the nurses station, and was observed to inform LPN-A of R104's pain.

-at 8:27 a.m. R104 was lying in bed on his right side, he was covered with a bed sheet from his feet to his mid chest. His eyes were opened, his jaw was tight, his lower body continued to jerk with spastic movements, each time R104 would

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F 697	Continued From page 17 gasp. -at 8:31 a.m. LPN-A entered R104's room, he indicated he was in severe pain, she administered as needed hydrocodone. R104 was observed for a total of one (1) hour and 15 minutes with symptoms and reports of pain, without being provided with any pain relieving interventions. During an interview on 9/28/22, at 7:23 a.m. NA-D stated R104 required extensive assistance of two staff with bed mobility, toileting of checking and changing and was able to verbalize his needs and wishes. NA-D stated R104 reported pain on a daily basis and indicated she had observed his lower body, legs exhibit spastic movements which would jerk his body. NA-D stated she had just told LPN-A R104 was having pain and had been told she would give him some medication. During a follow up interview on 9/28/22, at 8:29 a.m. R104 stated he had severe pain which routinely woke him up out of his sleep. He indicated he would like to speak to the doctor again to request an increase in baclofen as his leg spasms were so severe, they would cause his body to jerk and jump. R104 stated when he received his medication, it would take approximately 20 minutes to start to work and would try to ask for his pain medication before it became severe, however he indicated he would wait that long, on average, for any medication. R104 stated a few days prior, he was in so much pain, another resident from across the hallway had come to his room to see if he needed help and then went to the nurses station to tell them he was in pain. He indicated he felt, had it not	F 697		

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F 697	Continued From page 18 been for that resident, he would have likely stayed in agony waiting for them to answer his call light. R104 indicated he did not feel his pain was managed routinely. During an interview on 9/28/22, at 8:43 a.m. LPN-A indicated R104 had pain daily and received several routine and as needed medications for varying types of pain. She indicated R104 also received hydrocodone for pain as needed and was able to request the medication. LPN-A confirmed she had been told by NA-D, R104 was having pain earlier that morning, but was side tracked and had forgotten. LPN-A stated R104 would verbalize pain and would also moan and groan in pain routinely throughout the day. She indicated she had not heard R104 moaning or groaning earlier that morning, prior to her entering his room. She stated her usual practice would be to assess R104's pain, offer pain medications as needed, or requested. During an interview on 9/28/22, at 2:49 p.m. NA-E indicated R104 was alert and able to verbalize his needs and wishes. NA-E stated R104 required extensive assistance with all of his ADL's, was able to use his call light without difficulty. NA-E indicated R104 reported pain daily, with his lower back, body and legs. She indicated R104 had frequent leg spasms which would jerk his entire body and cause R104 to cry out in pain. NA-E stated, at those times, R104 would request pain medication, which she would inform the nurse of. NA-E stated she had not heard R104 report any concerns about not receiving his medication timely. During a telephone interview on 9/29/22, at 8:39	F 697		

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F 697	Continued From page 19 a.m. R104's primary medical doctor, (MD)-A indicated he had recently started seeing R104 since his admission to the facility. MD-A indicated he had been notified within the last week, R104 had complained of spasms and requested his baclofen to be increased, which it had been. MD-A indicated R104 had a complex medical history and had complex pain needs. He indicated he had worked with very few quadriplegic patients in the past and was not very familiar with treating the leg spasms associated with the paralysis. MD-A indicated he would expect R104 to have his pain assessed and to receive pain medication or intervention in a timely manner, such as within 15-30 minutes if the nurse was not busy elsewhere. MD-A indicated he would look at increasing R104's baclofen again in the future. During an interview on 9/29/22, at 10:17 a.m. CM-A indicated when R104 reported he was in pain, she would have expected his pain to be assessed and interventions implemented timely. She indicated R104 had been reporting and showing signs of pain since his admission along with some symptoms of anxiety. CM-A stated she felt R104's pain was related to leg spasms from his paralysis and had recently had his baclofen dosage increased on 9/21/22. She indicated she was not aware if there had been any improvement in R104's pain or any decrease in the intensity and/or duration of his leg spasms. During an interview on 9/29/22, at 10:47 a.m. the director of nursing (DON) indicated she would expect R104's pain to be assessed to include type, location, intensity, characteristics and what interventions, to include non-pharmacological, were effective. The DON stated she would have	F 697		

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F 697	Continued From page 20 expected R104's pain to be addressed and an intervention offered as soon as possible for pain level higher than 5-6 (moderate.) A facility policy titled, Pain Management - reviewed 12/7/21, identified it was the purpose of the policy to provide residents assistance in pain management, promote well-being by ensuring residents were comfortable, consistently collect data related to pain, determine what pain relief interventions specific to the resident could be used to aid in maintaining a comfortable level of of function and quality of life. The policy revealed the residents would be assessed for pain levels, monitor for pain, observe for effectiveness of both non-pharmacological and pharmacological pain relieving interventions. Further, the policy revealed residents with a history of pain or with a diagnosis that was oftentimes painful, would be reviewed weekly by the RN to update the residents MD as needed.	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		11/10/22

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F 758	Continued From page 21 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident was reassessed for continued use of an as needed (PRN) antipsychotic medication (medication used for a variety of mental health disorders), beyond the 14	F 758	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R48 was reassessed by behavioral	

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F 758	Continued From page 22 days for 1 of 5 residents (R48) who received an as needed antipsychotic medication reviewed for unnecessary medications. In addition, the facility failed to complete timely tardive dyskinesia (TD) screenings (assessment for involuntary movements) for 2 of 5 residents (R44, R28) reviewed for unnecessary medications, who received a routine dose of an antipsychotic medication. Findings Include: R48 R48's quarterly Minimum Data Set (MDS) dated 9/14/22, identified R48 had severe cognitive impairment and diagnoses which included: stroke, Alzheimer's disease, and dementia. R48's MDS indicated R48 received extensive assistance with bed mobility, transfers, dressing, personal hygiene and eating. R48's MDS identified R48 had no behaviors and received antipsychotic medications on a routine and PRN basis. R48's care plan last reviewed/revised 9/16/22, identified R48 had a potential problem related to psychotropic (any drug capable of affecting the mind, emotions and behavior) drug use, including the use of Haldol (antipsychotic medication) 2 milligrams (mg) three times a day as needed for agitation. R48's care plan identified diagnoses of dementia with behaviors, target behaviors of sadness, insomnia, crying and hallucinations. R48's care planned interventions included monitoring effectiveness of the program and periodic review by pharmacist. R48's Physician Order Report signed 8/26/22,	F 758	health nurse practitioner on 10/18/2022 and the medication was discontinued. R44 and R28 had AIMS completed on 10/14/2022. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. Any resident receiving Antipsychotic medications will be reviewed for appropriate orders and AIMS assessments completed timely according to facility policy and procedure. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. All residents admitted with a PRN antipsychotic will have a 14-day stop date entered into MAR. Facility procedure revised for admission of residents who receive as needed (PRN)Antipsychotic medications. Those residents will be evaluated for historical usage, and medication will be discontinued if not scheduled/ordered as needed (PRN). If appropriate, facility will receive proper order for the resident. Abnormal Involuntary Movement Scale (AIMS) assessment will be completed upon admission or when a new antipsychotic medication is first ordered and every 6 months thereafter. Residents on Antipsychotic medications will be reviewed at quarterly care conference for last AIMS assessment. Licensed nurses will be educated on Antipsychotic Medication Reduction policy during all staff meeting on 11/1 or 11/2.	

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F 758	Continued From page 23 identified: -Haldol 2 mg by mouth three times a day PRN, with a start date of 8/6/22, and no end date. Review of R48's medical record identified R48 was last seen 8/26/22, by R48's physician. R48's physician visit note dated 8/26/22, identified R48 had vascular dementia with agitation which had improved. R48's physician note medication listing included Haldol 2 mg by mouth three times a day as needed for agitation. R48's physician progress note identified no new orders. The note lacked documentation of an evaluation and an extension date beyond the 14 day renewal date of the PRN Haldol medication order. R48's medical administration record (MAR) dated 8/30/22, to 9/29/22, identified the following: -9/18/22, R48 received Haldol 2 mg at 4:19 p.m. -9/23/22, R48 received Haldol 2 mg at 4:37 p.m. -9/28/22, R48 received Haldol 2 mg at 4:01 p.m. R48's MAR identified R48 received Haldol PRN 3 times, up to 19 days after R48 was seen by his physician. Review of R48's pharmacy consultant Summary Reports dated 8/13/22, and 9/19/22, indicated no irregularities identified. The report lacked documentation to ask for reneal of the prn Haldol. During an interview on 9/29/22, at 8:28 a.m. clinical manager (CM)-A confirmed R48's last provider visit was completed on 8/26/22. CM-A confirmed R48 had received Haldol PRN three times since 8/30/22, and indicated R48's PRN Haldol order should have been renewed every 14 days.	F 758	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. Director of Nursing or designee will complete audits of 5 residents on antipsychotics weekly x4, bi-weekly times 2, monthly times 3 and quarterly until the QAPI committee has determined compliance has been attained. then monthly x2, observing for uncontrolled facial or hand movements. Facility will review with consulting pharmacist current residents on antipsychotics monthly.	

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F 758	Continued From page 24 During a telephone interview on 9/29/22, at 8:57 a.m. consultant pharmacist (CP)-A indicated PRN antipsychotic medications were not advised and a rationale for use should have been provided. CP-A stated antipsychotic medications used PRN required an order renewal after 14 days, unless the prescribing practitioner provided a stop date and a rationale. During an interview on 9/29/22, at 12:07 p.m. director of nursing (DON) confirmed R48 continued to receive Haldol PRN without the prescribing provider re-evaluating the continued use. DON indicated R48's Haldol PRN order should have been for 14 days, unless it was specified by the provider for a longer period of time. DON stated review of antipsychotic PRN medications use was important to assure the facility was not administering unnecessary medications when the residents did not require them since there were many possible side effects associated with antipsychotic medication use. R44 R44's Significant Change MDS dated 9/7/22, identified R44 had severe cognitive impairment and diagnoses which included: non-traumatic brain dysfunction, dementia, and manic depression. R44's MDS indicated R44 required limited assistance with bed mobility, transfers, and personal hygiene, as well as extensive assistance with dressing. R44's MDS identified R44 received routine antipsychotic medication. R44's Significant Change Care Area Assessment (CAA) dated 9/13/22, identified R44 had diagnoses of bi-polar disease (mental health condition marked by extreme shifts in mood) and	F 758		

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F 758	Continued From page 25 dementia and received psychotropic medications which included: paliperidone (antipsychotic medication) and risperidone (antipsychotic medication) whose dosages had not changed in the past quarter. R44's CAA identified R44's physician had noted drug induced Parkinsonism (neurological condition that causes difficulty with movement such as slow movement, stiffness and tremors) on 10/19/20, and had since documented this. R44's CAA indicated a trial to reduce antipsychotic medication failed on 6/21, and the care plan was updated to monitor for side effects and effectiveness. R44's care plan last reviewed/revised 9/13/22, identified R44 had a potential problem related to psychotropic drug use, with reason for drug use as bi-polar disease with paliperdone and risperidone with daily target behaviors of fearfulness and delusions. R44's care plan interventions included to provide medication as ordered by provider and use side effects monitoring tools, report side effects to provider and to monitor effectiveness, with periodic review by pharmacist. R44's Physician Order Report signed 9/19/22, identified: -paliperidone tablet extended release 1.5 mg tablet by mouth once a day -risperidone 0.5 mg tablet by mouth at bed time R44's Abnormal Involuntary Movement Scale (AIMS) (tardive dyskinesia screening tool) form dated 4/14/21, identified a score of 0.000 and indicated no changes since last assessment, no referrals necessary and continue current plan of care.	F 758		

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F 758	Continued From page 26 Review of R44's health record identified no further AIMS had been completed since 4/14/21. Review of R44's pharmacy consultant Summary Reports dated 7/18/22, 8/13/22, and 9/19/22, lacked recommendations for staff to complete an AIMS assessment on R44. R28 Findings include: R28's quarterly Minimum Data Set (MDS) dated 8/13/22, identified R28 was moderately cognitively impaired and had diagnoses which included diabetes mellitus, post-traumatic stress disorder and psychotic disorder. The MDS indicated R28 required extensive assistance with bed mobility, transferring, dressing, toileting, and hygiene. R28's MDS identified R28 received antipsychotic medication.	F 758		

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F 758	Continued From page 27 R28's care plan revised on 8/22/22, identified R28 had potential problems related to use of psychotropic drug use of Quetiapine for behaviors, hallucinations, and delusions. R28's care plan had various interventions which included to monitor and report any side effects. Review of R28's signed physician orders dated 8/9/22, identified R28 had an order for Quetiapine 25 mg take three tablets (75mg) by mouth every night at bedtime. Review of R28's medication administration record (MAR) from 7/1/22, to 9/29/22, revealed R28 received 75 mg of Quetiapine at bedtime daily. Review of R28's health record lacked an AIMS screening had been completed. During an interview on 9/29/22, at 11:50 a.m. CM-A confirmed the above findings and indicated R28 had started Quetiapine with his last hospital stay in August 2022. The CM-A indicated R28 should have had an AIMS completed when he returned from the hospital and indicated she would expect staff to follow the facility policy to ensure sure it had been completed. During an interview on 9/29/22, at 12:18 p.m. the DON confirmed the above finding and indicated an AIMS assessment should have been completed initially when starting the medication, every six months and with any changes in the antipsychotic medication. The DON indicated she would have expected staff to follow the facility policy to ensure the AIMS had been completed as scheduled.	F 758		

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F 758	Continued From page 28 During a telephone interview on 9/29/22, at 12:31 p.m. the CP-A confirmed the above findings and indicated a baseline AIMS assessment for involuntary movements should have been completed for R28 and R44. CP-A indicated staff were expected to complete the AIMS when an antipsychotic medication had been started, every six months and with any changes in the medication. The CP-A indicated he would expect staff to follow the facility's policy. During a follow-up interview on 9/29/22, at 12:36 p.m. DON confirmed R44's last AIMS assessment had been completed on 4/14/21, over 17 months ago. DON indicated her expectation was staff completed AIMS assessments every six months or more frequently if the resident had any changes in their condition, behaviors, mood, or any new changes were noted in antipsychotic medications. DON stated it was important to complete AIMS assessments to see if the resident had any side effects related to the use of antipsychotic medication which may affect their quality of life. The facility policy titled Psychotropic Medications-Rehab/Skilled reviewed 12/1/21, identified the purpose was to evaluate behavior interventions and alternatives before using psychotropic medications and to eliminate unnecessary psychotropic medications. The policy identified if the physician prescribed an antipsychotic medication for the resident, a registered nurse (RN) must complete the Initial Antipsychotropic Medication Assessment and the Abnormal Involuntarily Movement Scale (AIMS) . The policy indicated if the resident was on an antipsychotic, the RN must complete the AIMS every 6 months. The policy identified PRN orders	F 758		

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F 758	Continued From page 29 for anti-psychotic drugs were limited to 14 days and could not be renewed unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medication.	F 758		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to help reduce unnecessary antibiotic use and reduce potential drug resistance for 1 of 1 residents (R49) reviewed for urinary tract infection (UTI) as part of their antibiotic stewardship program. Findings include: The Center's for Disease Control and Prevention (CDC)'s Core Elements Of Antibiotic Stewardship For Nursing Homes, dated 2015, included recommendations to identify clinical situations which may be driving inappropriate use of antibiotics such as UTI prophylaxis and implement specific interventions to improve use. R49's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS) dated 3/15/22,	F 881	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R49 s physician has been notified and has discontinued medication on 10/6/2022. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. All residents who are currently on antibiotics have the potential to be affected by this deficient practice. All residents were reviewed for prophylactic and unnecessary antibiotic use. 3. What measures will be put into place, or systemic changes made, to ensure that	11/10/22

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F 881	Continued From page 30 identified R49 had diagnoses which included Alzheimer's disease, depression, bipolar disorder and anxiety. The MDS identified R49 was cognitively intact and was independent with activities of daily living (ADL's) which included toileting, dressing and bathing. The MDS revealed R49 received an antibiotic medication daily during a seven (7) day look back. The MDS did not identify R49 had a current UTI or had one within the last 30 days. R49's quarterly MDS dated 9/15/22, identified R49 had diagnoses which included Alzheimer's disease, depression, bipolar disorder and anxiety. The MDS identified R49 was cognitively intact and was independent with ADL's of toileting, dressing and bathing. The MDS revealed R49 received an antibiotic medication daily during the 7 day look back. The MDS did not identify R49 had a current UTI or had one within the last 30 days. R49's SCSA Care Area Assessment (CAA) dated 3/15/22, identified R49 had a diagnosis of Alzheimer's disease, had overall intact cognition and was independent with her ADL's. The CAA did not address R49's antibiotic use or any history of current concerns with a UTI. Review of R49's Physician Order Report dated 8/29/22, to 9/29/22, revealed the following: -an order dated 6/2/21, Cephalexin (a Cephalosporins, broad spectrum antibiotic - one that is effective against a wide range of bacteria) capsule, 250 milligrams (mg) by mouth daily for recurrent UTI. During an interview on 9/26/22, at 4:07 p.m. R49	F 881	the deficient practice will not recur. a. All residents with orders for an antibiotics were reviewed for inappropriate antibiotic use. Education will be provided to licensed nursing staff by DNS or designee on McGreer criteria. Nursing staff will also receive education on Antibiotic Stewardship policy and procedures, along with 72-hour timeout. This will ensure appropriate initiation of antibiotics for our residents. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. All residents who start an antibiotic will be reviewed to ensure they meet McGreer criteria, 72-hour timeout procedure followed to ensure appropriateness of antibiotic. This will be reported monthly for at least 6 months to quality assurance committee and infection preventionist or designee will follow up on non-compliance . QAPI committee will determine when compliance has been attained.	

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F 881	Continued From page 31 indicated she had recurrent UTI's and had been on an antibiotic since she arrived at the facility, approximately 20 months ago. She indicated when she had her last UTI, approximately a year ago, she had been quite sick with a fever and had urinary frequency and burning. R49 stated she was independent with all of her ADL's, was continent of urine and indicated she had not had symptoms of a UTI, (such as burning, pain, urgency or fever) for several months. During an interview on 9/29/22, at 8:40 a.m. clinical manager (CM)-A confirmed R49 received Cephalexin daily for UTI prevention. CM-A indicated R49 had been colonized with ESBL bacteria and felt this was the rationale for continued daily antibiotic use. She stated R49 had received intravenous antibiotics when she was admitted to the facility, over a year ago, and had been on oral antibiotics shortly thereafter. Review of R49's most recent urinalysis (analysis of urine by physical, chemical, and microscopic means to test for the presence of disease, drugs, etc.) and culture (a lab test to check for bacteria and other germs in a urine sample by incubation) dated 9/10/21, revealed R49 had mixed microflora (contains more than one organism and is highly indicative of a contaminated sample.) Review of R49's Consultant Pharmacist's Medication Review dated 2/15/22, indicated the pharmacist identified the following; due to the increased incidence of antibiotic resistance - the long term, indefinite use of antibiotics for UTI prophylaxis is generally not recommended. UTI treatment guidelines recommend against indefinite use of antibiotics. The pharmacist review revealed suggested course of action	F 881		

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F 881	Continued From page 32 included considering re-assessing the chronic use of Cephalexin, consider discontinuing, if appropriate and included a request to provide clinical rationale if the current benefits outweighed the risks. The form was signed by the pharmacy consultant. The form lacked any follow up from facility staff or R49's doctor. Review of R49's bi-monthly physician progress notes from 12/20/22, to 8/26/22, lacked documention or evidence R49's medical doctor addressed the continued prophylactic use of Cephalexin for recurrent UTI's. During a telephone interview on 9/29/22, at 9:00 a.m. the facility's consulting pharmacist (CP) confirmed R49 had a physician order to receive Cephalexin daily for recurrent UTI, since 6/2021. The CP stated the most recent pharmacy recommendation regarding R49's use of the antibiotic was 2/15/22, with a request for R49's provider to re-assess the choric use of Cephalexin. He was not aware of any follow up or response from R49's MD and confirmed he had not requested R49's antibiotic use be addressed since then. The CP indicated the risks of continued prophylactic antibiotic use placed R49 at risk for antibiotic resistance. During a follow-up interview on 9/29/22, at 10:24 a.m. CM-A confirmed R49's medical record lacked a rationale for continued use of the prophylactic antibiotic. She confirmed R49's most current urinalysis was a year ago and did not identify any specific bacteria's. During an interview on 9/29/22, at 10:40 a.m. the director of nursing (DON) stated R49 had been found colonized (the presence of bacteria in the	F 881		

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F 881	Continued From page 33 body without causing disease in the person) with ESBL in 2019. The DON confirmed R49 received Cephalexin for UTI prevention, despite colonization. The DON stated the facility had brought it to the attention of their consulting pharmacist and R49's primary physician. The DON stated the facility's antibiotic stewardship committee had discussed R49's use of the antibiotic in July of 2022, however she was not aware of a rationale for continuing the antibiotic. The DON stated she would expect the facility's infection control committee and antibiotic stewardship program to routinely address R49's continued use of the antibiotic, such as quarterly. Further, the DON confirmed there was no documentation R49's Cephalexin had been reviewed by the committee or by R49's MD within the last year. During a telephone interview on 9/29/22, at 12:35 p.m. R49's primary medical doctor's nurse confirmed R49 had been ordered an antibiotic (Cephalexin) daily for recurrent UTI's since June of 2021. The nurse confirmed R49 last had a urinalysis completed in September of 2021, and at that time, no culture had been completed to see what type of bacteria was present in the sample. The nurse indicated R49's doctor had spoken to her regarding the risks and benefits of using an antibiotic routinely in the past, however she confirmed there was no documentation of the education and she was not aware of when the conversation had taken place. She indicated she was not aware of when the last time, R49's medical doctor had last addressed the continued use of the prophylactic antibiotic. Review of a facility policy titled, Antibiotic Stewardship revised 11/29/21, revealed it was the	F 881		

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	245039	A. BUILDING _____ B. WING _____	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 881	Continued From page 34 purpose of the policy to: -provide guidance for antibiotic stewardship plans -decrease the incidence of multi-drug resistance organisms (MDROs) -promote appropriate use while optimizing the treatment of infections and reducing the possible adverse events associated with antibiotic use -provide standard definitions to be used as guidelines when initiating antibiotics The policy listed revealed a template plan for use to determine criteria for the initiation of antibiotics.	F 881		

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	245039	A. BUILDING **02 - BUILDING 1** B. WING _____	**09/29/2022**

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NEILSON PLACE	**1000 ANNE STREET NORTHWEST** **BEMIDJI, MN 56601**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/29/2022. At the time of this survey, Neilson Place was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/26/2022

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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NEILSON PLACE	**1000 ANNE STREET NORTHWEST** **BEMIDJI, MN 56601**

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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. Neilson Place was constructed in 2004, is 2-stories, without a basement and was determined to be of a Type I (332) construction. In 2009, 3 additions were constructed, a services wing to the south and connecting links to an apartment building to the north. The two connecting links into the north assisted living building are 1-story, Type II (111) construction. The building is divided into 3 smoke zones on each floor by 1 hour fire barriers. The facility has corridor smoke detection and	K 000		

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K 000	Continued From page 2 smoke detection in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code". All sleeping rooms have single station smoke detectors with annunciation in the corridor and at the nurse's station that serves that room with additional automatic fire detection in all rooms. The fire alarm is monitored for automatic fire department notification. The building is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a capacity of 78 beds and had a census of 78 at the time of the survey. The facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 372 SS=B	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 372		9/29/22

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K 372	Continued From page 3 Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/29/2022 between 10:00am and 1:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors to patient wings. An interview with Facilities Manager verified these deficient findings at the time of discovery. Deficiency was repaired before survey was completed 09/29/2022.	K 372	Hole in the wall was patched with fire rated material and fully sealed. Verified by Fire Marshal at time of survey. The manager of facility operations is responsible for tracking and correction of any other future penetrations.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)	K 761		10/31/22

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K 761	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct inspections of all fire rated doors required per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15.2 and 7.2.1.15.4 and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/29/2022 between 10:00am and 1:00pm, it was revealed by a review of available documentation the annual inspection fire rated doors have not been conducted since 2020. An interview with Facility Manaager verified this deficient finding at the time of discovery.	K 761	A complete check of fire rated doors will be completed and maintained on file. Inspection will be completed by the lead maintenance staff member and verified by the manager of facility operations.	