DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 26, 2022

Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

RE: CCN: 245315
Cycle Start Date: May 12, 2022

Dear Administrator:

On June 1, 2022, we notified you a remedy was imposed. On June 27, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 17, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 1, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 1, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 30, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 17, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 26, 2022

CMS Certification Number (CCN): 245315

Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 17, 2022 the above facility is certified for:

33 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 33 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

Electronically delivered
June 1, 2022

Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

RE: CCN: 245315
Cycle Start Date: May 12, 2022

Dear Administrator:

On May 12, 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 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:

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

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

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, Seasons Healthcare 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 November 12, 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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 5/9/22, to 5/12/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/9/22, to 5/12/22, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your 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. 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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		6/13/22

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

Electronically Signed | 06/10/2022

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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F 584	Continued From page 1 The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F 584		

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F 584	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up on concerns of missing personal items for 1 of 1 resident (R3) reviewed for missing personal property. Findings include: During an interview, on 5/9/22 at 3:15 p.m., R3 indicated she was missing a T-shirt, yellow in color with a kitty and birds, stated this was her favorite T-shirt. R3 indicated she had reported the missing T-shirt to staff approximately 10/2021 and was informed by staff they could not find, and had not been followed-up on since or replaced. When interviewed, on 5/10/22 at 10:56 a.m., nursing assistant (NA)-C indicated was not aware of any missing personal items for R3. During an interview, on 5/10/22 at 10:57 a.m., NA-D indicated was only aware of missing T-shirt for R3, believed the T-shirt had butterflies on it, missing for approximately six months. NA-D indicated when residents reports personal items are missing, staff will look for missing items, if unable to find will fill out a lost item form and turn form in to resident life coordinator (RLC) to follow-up on. When interviewed, on 5/10/22 at 10:59 a.m., laundry (L)-A indicated was aware of R3 missing a yellow T-shirt, picture of kitties in a basket go missing approximately one year ago. L-A indicated staff had been unable to locate missing items to her knowledge. L-A indicated all facility linen and resident's personal items, including clothing and bedding are laundered within facility.	F 584	Corrective action accomplished for affected resident - a shirt of the residents choice was ordered and she received it on 6/8/22. To identify other residents that may have been affected - at the May 26th resident council meeting, residents were asked if they had any missing items - none were identified. For those residents unable to attend the meeting the Resident Life Coordinator went to each resident and inquired if they were missing any items and none were identified. Measures put in place to ensure that the deficient practice doesn't recur - a missing or damaged item policy and procedure was developed and reviewed with all staff. The procedure was also addressed at the license nurses meeting on 5/19/2022. The facility will monitor this corrective action by reviewing all missing item reports for completion and for timely resolution at monthly and quarterly QA meetings. The administrator will audit that reports are done properly and timely.	

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F 584	Continued From page 3	F 584		

L-A indicated awareness of missing item procedure; staff are notified of resident's personal items missing, a lost item slip was filled out if staff could not locate missing items, form is turned into RLC to further follow-up on.

During an interview, on 5/10/22 at 11:06 a.m., licensed practical nurse (LPN)-A indicated was not aware of any personal missing items for R3. LPN-A indicated procedure for resident missing item; staff would look in resident's room for missing items, would call laundry department to notify to look for resident's missing items, staff would fill out missing item form, notify RLC of resident missing items, resident's family members notified of missing items, progress note made in electronic medical record (EMR) of resident missing item. RLC to follow-up on resident missing items.

When interviewed, on 5/10/22 at 11:19 a.m., RLC indicated was aware of R3's missing yellow kitty T-shirt, stated T-shirt went missing approximately 10/2021. RLC further indicated need to further follow-up on missing yellow kitty T-shirt. RLC indicated procedure for resident missing personal items includes; resident informs staff of missing item, missing, staff search for missing items, staff informed of resident missing items fill out missing item form if not found during shift, resident missing item form is routed to RLC for further follow-up. RLC indicated if resident missing items are not found; will replace through donated items if facility have in possession and resident approves, or facility will purchase missing items. RLC stated family members of resident missing personal items would be contacted, discussion of conversation with resident's family members documented in

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F 584	Continued From page 4	F 584		

progress note of EMR. RLC tried locating missing item form for R3's yellow kitty T-shirt, unable to find. RLC filled out a missing item form for yellow kitten T-shirt on 5/10/22, planned to further discuss replacement of lost item with R3. Review of progress notes in EMR were reviewed from 10/1/21-12/1/21, lacked documentation of staff discussion with R3's family members regarding missing yellow kitten T-shirt.

During an interview, on 5/10/22 at 11:59 a.m., director of nursing (DON)-A indicated process for resident missing personal items; staff look for missing items and if not found will fill out a missing items form, turn form into RLC. DON-A stated she was not aware of any missing items for R3. DON-A indicated resident missing items lost within facility would be replaced by facility. DON-A stated it was her expectation when residents report missing personal items to staff, residents are informed by staff of plan going forward. DON-A further indicated, going forward it would be her expectation residents are notified of resolution to missing personal item incidents within a month from reported time.

When interviewed, on 5/10/22 at 12:07 p.m., administrator indicated process for resident's missing personal items consisted of; resident would notify staff member of missing items, staff to fill out missing item form, staff to route missing item form to RLC, RLC searches for resident's personal missing items throughout facility, staff notify resident's family members, all staff on lookout for resident's personal missing items. Administrator stated residents would be notified with one-two days of personal missing items unable to be located. Administrator indicated resident's missing items would be replaced or

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F 584	Continued From page 5 reimbursed by facility if facility is responsible for losing personal items. Administrator stated residents and their family members should be notified by staff once personal missing items are unable to be located within 24 hours of plan going forward. Administrator confirmed R3 should have been informed per facility staff of resolution to personal missing item 10/21. A facility policy for resident missing personal property was requested from facility staff, but not received.	F 584		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F 676		6/13/22

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F 676	Continued From page 6 §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure activities of daily living (ADLs) were provided, including shaving for 1 of 2 residents (R13) reviewed, who needed staff assistance to maintain good personal hygiene. Findings include: R13's significant change in status Minimum Data Set (MDS) assessment, dated 3/28/22, indicated R13 had intact cognition and required assistance from staff to maintain personal hygiene. R13's care plan printed on 5/11/22; indicated R13 required staff assist of 1 to maintain personal hygiene, ADL function had deteriorated related to left side cerebral vascular accident (CVA), stroke. Care plan directed to ensure appearance is appropriate, staff assist of one with any facial hair removal if needed, staff uses electric razor. During an observation and interview on 5/9/22, at 3:55 p.m., R13 was observed to have facial hair	F 676	Corrective action for affected resident - R13 was immediately shaved on 5/11/22 once brought to the attention of the Director of Nurses that the resident's care plan stated shaving as needed had not been met. Verbal education was provided to the staff on duty at that time. To identify other residents with the potential of being affected - a visual examination upon the knowledge of R13 not being shaved according to the residents care plan was completed on all residents. It was found that there were no issues of facial hair on those resident's who prefer a clean shaven face. Measures put in place to ensure the deficient practice doesn't recur - An education memo was placed at the nurse's station on 5/19/22 reminding staff the importance of following the resident's care plan and how important it is to provide dignified care by providing all	

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F 676	Continued From page 7 stubble (short beard growth). R13 indicated he prefers to be clean shaven daily, has own shaver in room. R13 was observed on 5/10/22 at 11:34 a.m., to again have facial hair stubble (short beard growth). R13 was observed on 5/11/22 at 7:22 a.m., to continue to have facial hair stubble (short beard growth); had not been shaved in two days per observation. During an interview, on 5/11/22 at 7:27 a.m., with nursing assistant (NA)-A; indicated R13 was shaved every morning, occasionally would not be shaved if staff or R13's spouse observed skin drier, per R13's spouse preference. NA-A stated care plan indicated to shave R13 daily. NA-A reported she had noticed longer stubble/facial hair to R13, stated he should have been shaved. When interviewed, on 5/11/22 at 7:46 a.m., NA-B indicated being aware of R13's care needs, can look at care plan in electronic medical record (EMR). NA-B reported R13 needed assistance with maintaining hygiene, especially shaving. NA-B observed longer facial hair on R13, confirmed he should've been shaved; stated she did not "get him up" that morning. During an interview, on 5/11/22 at 7:59 a.m., licensed practical nurse (LPN)-A indicated being aware of R13's ADL needs, required staff assistance to maintain hygiene, especially shaving facial hair. LPN-A observed and verified R13 had longer facial hair, should have been assisted with shaving by staff. LPN-A indicated she would expect nursing staff to check care	F 676	residents who wish to be clean shaven to do so. The AM care policy and procedure was reviewed, and direct care staff were educated on the policy and procedure. Staff signed acknowledging understanding of the process. To monitor the corrective actions to ensure that the deficient practice is being corrected and will not recur - audits were performed on 6/6/22, 6/7/22, 6/8/22 and 6/9/22 and will be continued by the Director of Nurses or designated person on a weekly basis for the next month. If all audits proved to determine that the education provided has been effective, audits will then be done on a bi-weekly basis for the following quarter. Audits will be reviewed at the monthly and quarterly QA meetings.	

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F 676	Continued From page 8 plans for resident care needs or if questions to ask licensed nursing staff to clarify further directions. When interviewed, on 5/11/22 at 9:31 a.m., director of nursing (DON)-A indicated nursing staff should be checking care plans to find out what resident care needs are, perform cares as outlined per care plan. DON-A confirmed R13 should have been shaven daily per his care plan orders. DON-A further stated if nursing staff had questions about care needs, they should ask licensed nursing staff for clarification. During observation, on 5/11/22 at 9:47 a.m., DON-A and surveyor observed R13 was clean shaven. Review of facility policy titled, AM Cares, dated 12/1/17, included nursing assistants who are scheduled 11 pm-7 am and 7 am-2:30 pm are to assist with getting residents up in the morning, and helping with their cares. This includes but not limited to bathing the resident on their day, brushing teeth, washing up: face, body, and peri-area; combing hair, getting dressed, shaving if needed, etc. Basic Responsibility: Nurse Aides, Purpose: to refresh the resident, to provide cleanliness, comfort, and neatness. Procedure: Before beginning care, check the resident's care plan. Make note of special problems or special care needed by each resident. Resident care plans are individualized and give specific instruction on care. Shave resident as needed and/or desired.	F 676		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		6/13/22

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F 756	Continued From page 9 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756		

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F 756	Continued From page 10 Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were addressed or had a rational documented for not implementing recommendation related to tapering and discontinuation of psychotropic medications for 1 of 5 residents (R8) reviewed of unnecessary medications. Findings include: R8's admission face sheet, emailed on 5/16/22, identified R8 had a diagnosis of dementia (brain disorder that causes memory loss and impaired judgement) with behavioral disturbance, Major depressive disorder with psychotic features (mood disorder), psychosis (mental disorder causing disconnection from reality), Alzheimer's disease (progressive disease that destroys memory and mental functions), TIA (stroke). R8's current physician orders, emailed on 5/16/22, indicated R8 received sertraline (antidepressant) 150 mg daily for major depressive disorder with psychotic features and seroquel (antipsychotic) 25 mg three times daily for psychosis. R8's consultant pharmacist recommendations from 6/8/21 until 5/5/22 were reviewed. On 10/11/21, the consulting pharmacist recommended to discontinue prn (as needed) hydroxyzine (atarax), (antihistamine medication) for anxiety since it had not been used since 4/21, to complete 6-month evaluation for PHQ9 (scoring for depression) assessment and BIMS (cognitive) assessment due to R8's psychotropic medication use of quetiapine and sertraline. Furthermore, the consulting pharmacist	F 756	Corrective action accomplished for affected resident - Drug review recommendation was given to provider and provider reduced Seroquel on 5/31/2022. Reduction has proven to have undesirable effects resulting in negative behaviors. Seroquel was then increased by provider on 6/7/022. To identify potential other residents that may have been affected - all drug review recommendations from April and May 2022 were reviewed again to ensure that all had been followed up and they were. Measures put in to ensure that the deficient practice will not recur - Pharmacy Consultant policy and procedure was reviewed. Director of Nurses received clarification from the MDS Coordinator and pharmacy consultant regarding the review process of pharmacy recommendations on 5/19/22. Directors of Nursing will address recommendations within one week of receiving and immediate response reports will be forwarded to the primary care physician immediately, but no later than the next business day. The facility will monitor its corrective action by having the MDS coordinator audit monthly for one quarter to ensure pharmacy recommendations are being followed up on. These audits will be reviewed at monthly and quarterly QA meetings.	

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F 756	Continued From page 11 suggested tapering and discontinuation of R8's quetiapine and sertraline as tolerated. R8's behavior-medication monitoring form, dated 10/19/21, indicated facility had addressed with physician the consulting pharmacy's 10/11/21 recommendations to perform a 6 month PHQ9 and BIMS assessment, and discontinuation of prn hydroxyzine medication. However, upon further review of behavior-medication monitoring form, facility did not address with physician the consulting pharmacist's suggestion to taper and discontinue quetiapine and sertraline medications. Furthermore, R8's record lacked any documentation from the physician addressing consulting pharmacist's 10/11/21 recommendations to taper and discontinue quetiapine and sertraline medications. Monthly medication review regimens (MRR) were completed for R8 on 11/14/21, 12/14/21, 1/11/22, 2/3/22, 3/8/22 per consulting pharmacist; whom identified no problems with MRR during those times. On 5/5/22, consulting pharmacist recommended facility completed 6-month evaluation for PHQ9 assessment and BIMS assessment due to R8's psychotropic medication use of quetiapine and sertraline, and recommendation was addressed by facility staff. The consultant pharmacist also recommended tapering or discontinuation of R8's quetiapine and sertraline as tolerated however further review of record lacked documentation recommendation was addressed by physician. Record review of facility's behavior/intervention monthly flow record from 6/21-4/22, indicated R8	F 756		

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F 756	Continued From page 12 exhibited little to no inappropriate behaviors. When interviewed, on 5/12/22 at 1:01 p.m., DON-A indicated was unaware of consulting pharmacist's 10/11/21 recommendations to taper/discontinue as tolerated R8's quetiapine and sertraline as occurred before she started working at facility, DON-A confirmed that facility staff should have followed up on 10/11/21 recommendations, by reaching out to provider to further address suggestions to taper/discontinue quetiapine and sertraline medication . DON-A verified facility staff did not follow-up with physician regarding consulting pharmacist's 10/11/21 recommendations. During phone interview, on 5/12/22 at 3:41 p.m., consulting pharmacist confirmed her recommendations to taper and discontinue as tolerated R8's quetiapine and sertraline on 10/11/21, and again on 5/5/22; indicated she wasn't sure why 10/2021 recommendation were not followed up upon. Consultant pharmacist indicated needed to contact facility staff for further clarification. On 5/12/22 at 4:03 p.m., consulting pharmacist contacted surveyor by phone, stated she had spoken with facility staff regarding her 10/11/21 recommendations and was informed staff were unable to locate any documentation of 10/11/21 medication regimen review suggestions provided by pharmacy consultant, needed to look through the archives, as recommendations provided may have been in paper form. Consulting pharmacist stated facility staff had been good with follow through of all resident MRR recommendations, indicated her 10/11/21 MRR suggestions for R8 were probably in the archives, would contact	F 756		

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F 756	Continued From page 13 surveyor once found. No further contact was made to surveyor by facility staff or consulting pharmacist. Review of facility policy titled, Pharmacy Consultant, dated 12/1/17, consisted of; the monthly review by the consultant pharmacist will result in medication alerts regarding polypharmacy and psychotropic medication reduction requirements, the pharmacist will give the reports to the nurse in charge or the director of nursing, individual reports shall be forwarded to the resident's primary care physician and to the medical director after review by nursing, immediate response reports will be forwarded to the primary care physician immediately, but no later than the next business day; all other reports will be forwarded to the primary care physician or placed in the physician's file at the facility to be addressed with the next physician visit.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin was administered per standard of practice and manufacturer recommendations during 3 of 3 insulin administration for 3 of 3 residents (R7, R173, & R8). The facility's medication error rate was greater than 5% at 11.54 percent (%) rate.	F 759	Corrective action accomplished for those residents that have been affected - Residents R7, R8 and R173 were observed for any adverse reactions - none noted. Education was provided to non-compliant nurse regarding proper preparation of insulin pens on 5/11/2022.	6/14/22

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F 759	Continued From page 14 Findings include: On 5/10/22, at 11:25 a.m. licensed practical nurse (LPN)-C was observed preparing and administering insulin to R7 via a Novolog FlexPen (instrument used to deliver insulin.). LPN-A removed the cap off the FlexPen, swabbed insulin pen port with alcohol and then attached a disposable needle to the rubber stopper at end of the pen. After attaching the needle to the FlexPen, LPN-A dialed 1 unit, and primed pen (getting insulin ready to dose by getting rid of air that may collect in insulin pen) and with needle pointing down, then dialed to 5 units and administered the insulin into R7's abdomen. LPN-C returned to cart, discarded needle and prepared R8's insulin pen by swabbing Novolog FlexPen port with alcohol attaching a new disposable needle and priming pen using 1 unit with needle pointing down. LPN-A wheeled R7 into entryway of director of nursing office, dialed Novolog FlexPen to 2 units and administered insulin into R8's abdomen. LPN-A returned to cart and discarded needle. On 5/10/22 at 11:43 a.m., LPN-A went to dining room and wheeled R173 to medication cart. LPN-A checked dosage on computer, cleaned Novolog FlexPen hub, put on new needle and primed with 1 unit of insulin with needle pointing down, then dialed to 18 units and injected in right lower abdomen. LPN-A removed gloves, covered insulin container box and placed back into cart. R7's physician order included Novolog Flexpen U-100 insulin 100 units/ml, give 5 units subcutaneous before meals. R8's physician order included Insulin aspart	F 759	To identify other residents that had the potential of harm due to this deficient practice - all other insulin dependent diabetics were observed and no adverse reactions were noted. Measures put in place to ensure that the deficient practice will not recur - all licensed nurses were provided education at a nurses meeting on 5/19/2022 regarding proper preparation of insulin pens. Pharmacy consultant to provide training at a nurses meeting on 6/14/2022. Facility policy and procedure regarding insulin administration was reviewed and revised. Insulin pen preparation/administration has been added to new hire orientation & competencies for all license nurses. The facility will monitor its corrective action to ensure the deficient practice is corrected and will not recur by auditing monthly each nurse to ensure they are preparing insulin correctly. Audits will be reviewed at monthly and quarterly QA meetings.	

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F 759	Continued From page 15	F 759		

insulin pen 100 units per ml, 2 units subcutaneous twice a day, 8:00 a.m. and 12:00 p.m..

R173's physician order included Novolin Regular 100 units/ml, give 18 units with meals.

The Novolog FlexPen manufacturer's Instructions For Use included: A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. B. Remove the protective tab from a disposable needle. Screw the needle tightly onto your FlexPen. C. Pull off the big outer needle cap. D. Pull off the inner needle cap and dispose of it. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units. F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the Novolog FlexPen .

During interview on 5/10/22, at 1:14 p.m., LPN-A confirmed she primed the Novolog FlexPen with 1 unit of insulin for R8, R7 and R173. LPN-A indicated she was taught to prime insulin pens with 1-2 units in nursing school and again when she started here.

During interview on 5/11/22, at 12:45 p.m., the director of nursing (DON)-A confirmed insulin pens should be primed with 2 units of insulin prior

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F 759	Continued From page 16 to administration per manufacturing instructions. A policy titled Insulin Administration using Insulin Pens dated 2/3/20, included: The facility endeavors to assure that all residents, whom receive Insulin, will have it properly administered so as to be free of any significant medication errors and to be free of any complications of the injection itself. Each time an insulin pen is used, prime the pen, then call up the right dose.	F 759		
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,	F 880		6/14/22

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F 880	Continued From page 17 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; (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.	F 880		

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F 880	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was followed to prevent the spread of infection for 5 of 5 residents (R21, R14, R7, R8 and R173) observed during medication administration. Findings include: On 5/10/22, at 8:15 a.m., a continual observation of license practical nurse (LPN)-A was observed during administration of medications to R14 and R21. LPN-A was observed in the nurses station and returned to medication cart. LPN-A, without completing hand hygiene, touched computer, opened the medication cart and began to set up R14's medications using medication cards placing medication into a cup. LPN-A then filled a cup with applesauce and entered R14's room. LPN-A picked up R14's water glass and offered her a drink, then using a spoon, LPN-A scooped up 2 medications at a time, mixed with applesauce and spoon fed R14 her medications. R14 then took another drink of water and handed water glass back to LPN-A who set it on bedside table. LPN-A then discarded medication cups, left the room and returned to the medication cart. LPN-A then documented medication administration in the electronic medical record (EMR). LPN-A then took out R21's medication cards and began placing medications in individual medication cups. LPN-A then entered R21's room. LPN-A placed medication cups on counter, picked up syringe that was in 2 pieces and placed plunger into syringe. LPN-A then emptied medications one at at time into pill crusher then placed medications back into cups. LPN-A then	F 880	Corrective action was accomplished for those residents found to be affected - Residents R21, R14, R7, R8 and R173 were observed and found to have no harmful affects from the deficient practice. To identify other residents having the potential to be affected by the same deficient practice - all resident's illness/infection status was reviewed - no issues noted and no current outbreaks at this time. A RCA was completed and indicated that the facility's new hire orientation and competencies did not address hand hygiene with medication passes. Measures put in place to ensure that the deficient practice will not recur - nurse found to be non-compliant with hand hygiene during med pass was educated by the Director of Nursing on 5/13/22 following surveyors findings. Education material "Core Practices Table" from HICPAC was given to this nurse on 6/7/22 with facility policy titled "Infection Control Hygiene". All licensed nurses were educated on 5/19/22 at nurse's meeting on hand hygiene. Also, a handwashing video and hand sanitizer video training were provided to all staff on 6/6/22. Facility medication administration policy and procedure was reviewed and revised. Nurse and TMA orientation & competency checklists have been updated to include	

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	245315	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

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F 880	Continued From page 19 put on gloves, placed water in container and administered medications through gastrostomy tube (surgically placed device used to give direct access to stomach for supplemental feeding, hydration or medication). LPN-A discarded medication cups, removed gloves, left room and returned to medication cart. No hand hygiene was observed during this continual observation. During continual observation on 5/10/22, at 11:25 a.m., LPN-A was present at medication cart. LPN-A removed 3 individual insulin/glucometer kits from the cart and placed them on top of cart. LPN-A grabbed R7's kit and pushed R7 into hallway of director of nursing (DON) office. LPN-A set kit on bedside table, put on gloves and checked blood sugar with glucometer from the kit and administered insulin. LPN-A assisted R7 into the hallway and returned to medication cart. LPN-A assisted R8 into hallway of director of nursing (DON's) office, retrieved glucometer reader (R8 had a continuous glucometer monitor) from R8's room and completed blood sugar reading. LPN-A put on gloves and administered insulin dose and returned to medication cart. LPN-A then went to dining room and wheeled R173 to medication cart parked at the nurses station. LPN-A then placed on gloves and administered insulin per order. LPN-A removed gloves and completed documentation. No hand hygiene observed throughout observation. During interview on 5/10/22, at 1:14 p.m., LPN-A indicated she did not complete hand hygiene during medication administration and has been trying to do better with hand hygiene. During interview on 5/11/22, at 12:46 p.m., the DON-A indicated staff are expected to perform	F 880	hand hygiene with medication pass as this was found to be the root cause of the issue. On 6/14/22 facility Pharmacy Consultant provide a training for all license nurses "Medication Administration in the LTC Facility that also addressed handwashing. To monitor our corrective actions to ensure that the deficient practice is being corrected and will not recur - hand hygiene audits are being conducted with licensed nurses and with TMAs during medication pass, any issues will be addressed immediately and further education given to the individual. Results of the audits will be reviewed and monitored at monthly and quarterly QA meetings. The Directors of Nursing will be responsible for monitoring the audits and results. A QA action plan was developed and reviewed by the facility's QA committee and Boverning Body President on 6/14/22.	

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F 880	Continued From page 20 hand hygiene between all medication administrations between residents. A policy titled "Medication Administration" last reviewed 12/1/17, included: -Identify drugs to be administered on the MAR (medication administration record) -Identify resident -Wash or sterilize hands prior to drug administration -Prepare medication for administration -Administer medication and observe ingestion of all orally administered medications -Document on the MAR that the medication has been administered. According to CDC's "Hand Hygiene in Healthcare Settings," last reviewed on 1/30/20, "The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings: -Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications:...After touching a patient or the patient's immediate environment..."	F 880		
F 881 SS=F	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:	F 881		6/16/22

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F 881	Continued From page 21 §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 implement a process for antibiotic review to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any of the 27 residents who resided in the facility who might use antibiotics. Findings include: Review of facility monthly infection control logs for 2/22, 3/22 and 4/22; lacked documentation related to the date of onset of infection, date cultures taken, organisms noted from culture obtained, if resistant to antibiotic, duration of antibiotic therapy to be completed, resolution of antibiotic therapy, how organism was acquired, isolation precautions, communication with physician of resident status while on antibiotic therapy. Logs lacked previous months infection control monitoring prior to 2/22. Review of monthly surveillance control log included an undated floor plan of facility. Surveillance log included resident room numbers listed, and key at bottom of floor plan had UTI (urinary tract infection) and Covid listed. UTI had a yellow mark next to it, Covid had a blue mark next to it. The floor plan did not include any information related to infection such as, resident rooms highlighted in yellow or blue colors to indicate type of infection, symptoms, date infection was first noted, culture and results, antibiotic order, resolution date and outcome.	F 881	Corrective action accomplished for those residents found to have been affected - all residents potentially could have been affected - Directors of Nursing reviewed resident's health statuses and found no issues based on infections/antibiotic use found. No current outbreak of any illness noted. Measures put into place to ensure that the deficient practice will not recur - The Infection Control/Antibiotic Stewardship log was brought up to date from February 2022 - current. The Director of Nursing will be completing Infection Control Training June 13 - 17, 2022. Antibiotic Stewardship policy and procedure was reviewed. Forms were reviewed and revised to meet policy and procedure. Nurses were educated on reporting antibiotic use/other illness to the Infection Control RN using Antibiotic and Illness/Infection Reporting tools. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by performing audits on the log weekly for one month and then move audits to monthly if no issues found. All audits will be reviewed at the monthly and quarterly QA meetings. Directors of Nursing will be responsible for these corrective actions.	

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F 881	Continued From page 22 When interviewed at 12:32 p.m. on 5/12/22, director of nursing (DON)-A stated she was sharing the DON position with DON-B, whom were newer employees, both starting DON position in 11/21. DON-A stated she and DON-B were going through training, and DON-B was out of office during week of survey due to training; DON-B was responsible for the infection control program, including antibiotic stewardship. DON-A confirmed DON-B had not completed infection control/prevention, antibiotic stewardship program yet, unable to verify date for scheduled upcoming training. DON-A indicated she and DON-B were always aware of any resident infections, infection tracking/surveillance was discussed during daily stand-up meetings to keep up with resident status. DON-A was asked about infection control monitoring logs prior to 2/22, DON-A indicated she was unable to locate. DON-A was asked about surveillance log monitoring, indicated DON-B was just starting to put it together, no other information provided. DON-A confirmed many problem areas with infection control monitoring and surveillance/tracking system in place, and indicated a process change had started, but was not yet completed. DON-A indicated nursing staff were documenting and monitoring resident infection status through progress note in electronic medical record (EMR) system. The policy titled, Antibiotic Stewardship Program (ASP), revised 10/25/18, consisted of: Antibiotic stewardship programs (ASPs) are designed to minimize the harmful effects of inappropriate antibiotic use The most serious concern with antibiotic resistance is that some bacteria have become	F 881		

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F 881	Continued From page 23 resistant to some of the easily available antibiotics (Multi-Drug Resistant Organisms or MDROs), these bacteria can cause serious disease, and this is a major public health problem. Utilizing stewardship actions such as measuring a facility's antibiotic use promotes prudent use and management of antimicrobial agents, reduces antibiotic resistance, and increase optimal patient outcomes Will compile and share report of antibiotic use, process measures, and outcomes monthly and compiled/presented at quarterly QA meeting Action to support antimicrobial use; review of current antimicrobial use, observation of trends of antimicrobial use, consult with prescribers on appropriate antimicrobial selection, pharmacy driven interventions (dose adjustments, automatic alerts for duplicates, time sensitive automatic stop orders, prevention of antimicrobial related drug-drug and/or drug-food interactions, and recommendations for specific infections and syndromes; communication with providers in selecting antimicrobial therapy based on evidence-based practices, review of culture and sensitivity reports, education for nursing staff regarding monitoring residents with an infection including response to antimicrobial therapy, plan of care for the resident with an infection; facility-wide surveillance of all diagnosed infections. Tracking and reporting of antibiotic use in order to guide practice change and track ASP impact; DON and licensed nurses track all prescribed antimicrobials by prescriber, resident, indication, unit, and antibiotic; additional information to be tracked- resident information, infection, culture, antimicrobial starts, classification, other information	F 881		

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F 881	Continued From page 24 (transmission-based precaution/symptom resolution), data is collected weekly and logged, data is reported to the ASP team monthly and at quarterly QA meetings. The policy titled, Infection Control Resident Surveillance, revised 12/23/19, included: The Trimont Health Care Center will systematically collect data on residents to determine whether a nosocomial infection is present. Criteria Guidelines and definitions are adapted from McGreer. Purpose: Surveillance data will be used to: prevent infectious transmission to others, detect infections that need treatment and improve outcomes and processes. Procedure: 2. The Infection Control Nurse and/or the Director of Nursing will analyze the collected data and the incidence of infections will be determined on a monthly (or as needed) basis. 3. Data collected will be on the monthly infection log and infection summary. 4. Monthly data will be reviewed by the Infection Control Nurse and the Director of Nursing 6. Control measures will be instituted as appropriate to identified problems including sentinel events 7. Antimicrobial tracking will be also used to monitor trends/frequency	F 881		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member	F 887		6/13/22

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F 887	Continued From page 25 is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered	F 887		

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F 887	Continued From page 26 to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure COVID-19 vaccination doses were offered to 1 of 5 residents (R12) reviewed for COVID-19 vaccination status. Findings include: R12's face sheet, printed on 5/12/22, indicated R12 was admitted to the facility on 2/2/22. Review of R12's immunization summary, printed on 5/10/22, lacked documentation of Covid-19 vaccine dose being administered. Review of R12's medical record lacked documentation R12 was offered the COVID-19 vaccine upon and/or after admission, nor was provided education related to the risk and/or benefits of the vaccine. R12's medical record lacked documentation COVID-19 vaccine was administered or contraindicated. Furthermore,	F 887	Corrective action accomplished for those residents found to have been affected - R12 returned from the hospital on 5/19/22 and upon readmission, the facility obtained a declination of COVID-19 vaccination. Other residents identified having the potential to be affected by this deficient practice - all unvaccinated residents were found to have a declination of COVID-19 vaccination in their medical record. Audits of new admissions show that all of them had been given an opportunity to receive the vaccinations and the consent/declination forms had been completed. Measures put in place to ensure that the deficient practice will not recur - a new consent/declination form was created and	

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F 887	Continued From page 27 R12's consent and/or declination form for Covid-19 vaccine was requested from facility but not provided. During an interview, on 5/12/22 at approximately 10:00 a.m., licensed practical nurse (LPN)-B indicated resident immunization status was addressed at time of admission; vaccine education and consent form provided by licensed nursing staff to resident and/or resident representative, signature obtained by resident and/or resident representative indicating consent or declination to vaccine administration. LPN-B stated she was unable to find Covid-19 vaccine consent or declination form for R12, would need additional time to look through electronic medical record (EMR) system. No further information was provided. When interviewed, on 5/12/22 at 1:01 p.m., director of nursing (DON)-A indicated all resident's immunization status were verified at time of admission and included; education on risk/benefits of vaccines, administration of immunizations if wanted/needed/available, and vaccination consent/declination forms provided/signed by staff and resident and/or representative. DON-A stated it was her expectation licensed nursing staff ensure resident's immunization status were verified and updated as indicated at time of admission. DON-A confirmed R12's immunization status had not been verified or updated upon medical record review and should have been. Facility policy related to COVID-19 was requested however was not provided.	F 887	education provided to the license nurses on 5/19/22. A copy of the COVID-19 Immunization policy and procedure was reviewed with a highlighted and laminated copy being placed at the nurses station. Admission checklist was revised to include immunization consent/declination form completed. The facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur by the Directors of Nursing or designated individual performing audits on all Admission Checklists and new admissions into the facility to ensure that consents/declinations are being completed. Audits will be reviewed at our monthly and quarterly QA meetings.	

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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 05/12/2022. At the time of this survey, SEASONS HEALTHCARE 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		06/10/2022

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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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. SEASONS HEALTHCARE is a 1 story building with partial basement. The original building was constructed in 1963, one-story with partial basement, and was determined to be of Type II (111) construction. In 1992 a Chapel addition was constructed, one-story with no basement, having a 2-hour separation from the original building, and was determined to be of Type V(111) construction.	K 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 36 beds and had a census of 22 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the exit discharge per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7 and 7.1.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/12/2022, between 09:30 AM to 11:30 AM, it was revealed by observation during the tour of the facility that on the exterior of the East Exit Door, the concrete was degraded and breaking up, presenting a fall and trip hazard in the path of	K 271	Corrective action - removed concrete square at East Exit entrance and replaced cement to fix crack and deterioration. Ground and cut edge to prevent tripping hazard. To ensure deficiency doesn't reoccur - Environmental Service Director will inspect exit egresses for safety when performing monthly facility walk through. To monitor to ensure solution is sustained - Environmental Service Director will report egress observations at monthly	6/7/22

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	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/12/2022**

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K 271	Continued From page 3 egress. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 271	safety meeting. The Environmental Service Director is responsible for corrective action and monitoring for compliance.	
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 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, document review, and staff interview, the facility failed to inspect and maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, 5.2.1.1.2, 5.3.2.1, and 14.2.1. These deficient findings could have a widespread impact	K 353	Corrective action for #1 - Johnson Controls was contacted by the Environmental Service Director, to set a date for the 5 year internal sprinkler inspection. Corrective action for #2 - the speaker and cabling attached to the sprinkler pipe was removed on 5/12/2022.	6/17/22

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K 353	Continued From page 4 on the residents within the facility. Findings include: 1. On 05/12/2022 between 09:30 AM to 11:30 AM, it was revealed by observation that the sprinkler system riser gage was dated 02/2017. During documentation review, no documentation was presented for review to confirm the 5 year sprinkler system inspection had been completed. 2. On 05/12/2022 between 09:30 AM to 11:30 AM, it was revealed by observation in Wing 100 that cabling was zip-tied to the sprinkler piping and an audio speaker was positioned and resting on top of sprinkler piping. An interview with the Facility Director verified these deficient finding at the time of discovery.	K 353	Measures put in place to ensure deficiency doesn't recur for #1 - Environmental Service Director will use a calendar to remind when the 5 year inspection is coming due and to contact the vendor prior to that month to secure a date for a timely inspection. Measures put in place to ensure deficiency doesn't recur for #2 - The sprinkler piping will be audited monthly for 3 months and results to be reviewed at the safety committee meeting to assess the need for continuance of audits to ensure there are no items attached. The Environmental Service Director will check this during his monthly environmental round observations. These rounds will be reviewed at the monthly safety meetings. The Environmental Service Director is responsible for these corrective actions.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal	K 374		6/1/22

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K 374	Continued From page 5 doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/11/2022 between 09:30 AM to 11:00 AM, it was revealed by observation that upon testing of the smoke barrier doors of the Chapel they did not properly self-close to resist the passage of smoke. An interview with the Facility Director verified this deficient finding at the time of discovery.	K 374	Corrective Action - the smoke barrier doors of the chapel were adjusted on 6/1/22 so that they properly self-close. Measures put in place to ensure deficiency doesn't reoccur - smoke barrier doors observation was added to the facility Fire Drill Report. Plan to monitor to ensure solutions are sustained - when a fire drill is completed each month the Environmental Service Director will check that the fire doors self-close properly and document findings o the Fire Drill Report form. The Environmental Services Director will bring the Fire Drill Report to the monthly safety meeting for review. The Environmental Services Director is responsible for the corrective action and monitoring of this deficiency.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or	K 923		6/14/22

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K 923	Continued From page 6 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, section 11.3.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/11/2022 between 09:30 AM to 11:00 AM, it	K 923	Corrective Action - The freestanding and unsecured med gas cylinder found at the nurses station was removed and secured in the proper storage location on 5/12/22. Measures put in place to ensure deficiency doesn't reoccur - The Oxygen Use policy and procedure was reviewed and revised to include the location of where an empty cylinder is to be secured.	

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K 923	Continued From page 7 was revealed by observation that at the Nurses Station there was a freestanding and unsecured Med Gas cylinder on the floor. An interview with the Facility Director verified this deficient finding at the time of discovery.	K 923	This policy and procedure was provided to each employee and each employee then signed off that they received the education. Plan to monitor to ensure solution is sustained - the revised Oxygen Use policy and procedure will be reviewed with all new hires and at the annual All Staff Education Meeting. The Environmental Services Director and the Director of Nurses will monitor to ensure that gas cylinders are secured in the proper locations.	
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 on a review of available documentation the facility failed to provide documentation associated training of personal related to gases in cylinders and liquefied gases in cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2. This deficient finding widespread impact on the residents within the facility.	K 926	Corrective Action - an education packet developed by Northwest Respiratory Services titled "Oxygen Administration & Safety" was given to staff to read and sign acknowledging they received and read the material. Measures put in place to ensure	6/14/22

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K 926	Continued From page 8 Findings include: On 05/11/2022 between 09:30 AM to 11:00 AM, it was revealed by a review of available documentation that no documentation was presented for review to confirm initial training of staff and refresher training associated to gases in cylinders and liquefied gases in cylinders used in the facilty. An interview with the Facility Director verified this deficient finding at the time of discovery.	K 926	deficiency doesn't reoccur - Oxygen administration education packet and Oxygen Use policy and procedure will be reviewed with all new hires and at the annual All Staff Education Meeting. To monitor to ensure solutions are sustained - the new hire orientation checklist will reflect that the education was given. Annual training on oxygen will be completed by the Director of Nursing. The administrator will audit the orientation checklists for compliance with new hires and will ensure that all staff education is completed annually.	