DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 9, 2022

Administrator
Parkview Care Center - Wells
55 Tenth Street Southeast
Wells, MN 56097

RE: CCN: 245436
Cycle Start Date: April 28, 2022

Dear Administrator:

On July 19, 2022, we notified you a remedy was imposed. On August 4, 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 July 26, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 28, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 20, 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 July 28, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 26, 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 Therefore, the NATCEP prohibition is rescinded.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.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the April 28, 2022 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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
August 9, 2022

CMS Certification Number (CCN): 245436

Administrator
Parkview Care Center - Wells
55 Tenth Street Southeast
Wells, MN 56097

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 July 26, 2022 the above facility is certified for:

30 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 20, 2022

Administrator
Parkview Care Center - Wells
55 Tenth Street Southeast
Wells, MN 56097

RE: CCN: 245436
Cycle Start Date: April 28, 2022

Dear Administrator:

On April 28, 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:

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, 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 July 28, 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 October 28, 2022 (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,

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
	245436	A. BUILDING _____ B. WING _____	04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER - WELLS	55 TENTH STREET SOUTHEAST WELLS, MN 56097

(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 4/25/22 - 4/28/22, 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 4/25/22, to 4/28/22, 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 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 that substantial compliance with the regulations has been attained.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment	F 636		7/5/22

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

Electronically Signed | 05/27/2022

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 636	Continued From page 1 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff	F 636		

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F 636	Continued From page 2 members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for 1 of 1 resident (R5) reviewed for urinary tract infection (UTI). Findings include: R5's admission Minimum Data Set (MDS) assessment, dated 1/12/22, indicated R5 had diagnoses which included renal (kidney) insufficiency (kidneys lose the ability to remove waste and balance fluids). R5's MDS also indicated resident was always continent of urine. R5's admission record face sheet, printed on 4/28/22, indicated diagnoses of acute cystitis (sudden inflammation of bladder) without hematuria (blood in urine), chronic kidney disease, overactive bladder (condition causing	F 636	F636 Comprehensive Assessments & Timing It is the facility's intent to comply with the regulation to provide a complete and timely comprehensive assessment. The corrective action that was taken for R5, the care plan, was updated to reflect a history of incontinence, UTI, and necessary monitoring, bowel, and bladder assessment completed on 5/12/2022. The resident was also provided further education on peri-care due to her being semi-independent. All residents were assessed and evaluated then the care plans were audited and updated as needed to ensure the care plans accurately addressed urinary incontinence and/or UTI monitoring and prevention. The facility identified that all residents	

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F 636	Continued From page 3 sudden need to urinate), urinary incontinence (inability to control urination), and personal history of urinary tract infections, R5's quarterly MDS assessment, dated 4/6/22, indicated occasional urinary incontinence, not on urinary toileting program, had UTI within past 30 days. Furthermore, R5's care area assessment (CAA) was not triggered, or care planned for urinary incontinence/UTI monitoring and prevention. R5's discharge MDS assessment, dated 4/15/22, indicated occasional urinary incontinence, urinary toileting program was not marked/left blank. Furthermore, R5's diagnoses did not indicate any urinary conditions, section was left blank; CAA was not triggered, or care planned for management of urinary incontinence. Physician order summary, ordered 1/6/22, indicated if symptoms of infection (cough, runny nose, fever, UTI symptoms etc.) do Active Infection Monitoring under assessments every shift if symptoms remain. Facility progress notes reviewed from 3/1/22-4/27/22; -On 3/7/22 at 8:36 a.m., R5 complained of urinary frequency, suprapubic pain, burning with urination, and urinary urgency; provider contacted and ordered urinalysis (UA). -On 3/8/22, R5 diagnosed with UTI, started on Bactrim DS x5 days. -On 3/10/22, provider extended Bactrim DS for additional 2 days, ordered post-void residual (PVR) for urinary retention. -On 3/15/22, at 10:34 a.m., R5 voided 75cc of urine toilet, was bladder scanned, had 198cc of	F 636	were at risk for harm due to a lack of comprehensive resident assessments and timeliness of completion. The measures that were put into place was 1) MDS audits for accuracy and timeliness will be completed. Facility-wide audits on completed MDS assessments will be conducted randomly, no less than 5 audits will be completed by a trained individual, to assess for substantial accuracy. Further education and training for the MDS coordinator will be provided based on audit results regarding the accuracy and timeliness of the completion of a comprehensive assessment. MDS coordinator was provided education on the importance of communication with residents and licensed and non-licensed staff while completing the comprehensive assessment. Education with MDS Coordinator to review diagnosis list and ensure accuracy with information obtained through the assessment process. 2) IP nurse and DON will provide re-education for all licensed nurses on expectations to complete Infection monitoring Assessment as ordered in Physician Order. Re-education, including proper peri care, wiping after void or BM from front to back, voiding when the urge is felt to prevent retention and changing incontinent garments when soiled, and performing peri care at that time, was provided to resident R5.	

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F 636	Continued From page 4 urine remaining in bladder at time. At 9:20 p.m., R5 voided 75cc of urine in toilet, was bladder scanned, had 204cc of urine remaining in bladder at time. -On 3/19/22, at 3:05 a.m., R5 reported not feeling well, had 1 episode of emesis, vitals stable. -On 3/23/22, at 8:35 p.m., R5 requested to eat in room, needed reminders food was on table, ate meal, sat in recliner, slept off and on throughout evening. -On 4/6/22, at 1:21 p.m., R5 appeared more confused and sleepier. -On 4/15/22, at 7:01 p.m., R5 had change of condition with shortness of breath and fast heart rate. R5 declined to go to hospital. At 8:38 p.m., R5 continued to have symptoms of shortness of breath and fast heart rate, continued to refuse hospital visit, provider was contacted. At 9:40 p.m., R5 agreed to go to hospital, was transported per ambulance. -On 4/16/22, at 10:37 a.m., facility staff were informed R5 was admitted to hospital with sepsis from UTI. -On 4/20/22, at 5:15 p.m., R5 returned from hospital back to facility. -On 4/27/22, at 1:09 p.m., R5 had been medically stable since return from hospital. When interviewed, on 4/26/22 at 9:33 a.m., R5 indicated was recently sent to hospital for UTI, was taking antibiotic for UTI; antibiotic therapy completed. R5 indicated had urinary incontinence for many years, wears a pad for urinary leakage. R5 indicated she had a UTI prior to recent hospitalization, approximately 1 month ago, was treated with oral antibiotic therapy. Since hospital return on 4/20/22, R5 indicated she had generalized weakness, required staff assistance with peri-care and pad/brief change.	F 636	IP nurse and DON will provide re-education for all licensed nurses and unlicensed nursing staff on urinary incontinence, and urinary tract infections, including but not limited to symptoms of urinary tract infections, reporting and documentation of, and preventative measures including proper peri care procedure. IP nurse and/or designee will complete 5 peri care audits each week on varied shifts for 4 weeks and then will complete a minimum of 3 random peri care audits per week for 8 weeks with continued random peri care audits thereafter. The DON and/or RN designee will review the residents prior to admission determining any potential risk factors for urinary incontinence and/or UTI monitoring and prevention. Then upon the decision to admit the care plan will be audited to ensure appropriate preventative measures are in place. The facility will monitor 1) The accuracy and timeliness of the comprehensive assessments by completing random audits x 1 quarter after the initial MDS audit is completed or until satisfied that the accuracy and timeliness of comprehensive assessments are routinely within compliance. The accuracy and completeness of care plans related to urinary incontinence by completing random audits x 1 quarter or until satisfied that accuracy and completeness of care plans are routinely within compliance. 2) IP nurse and/or designee will audit all	

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F 636	Continued From page 5 R5 indicated prior to recent hospitalization, she handled toileting cares needed independently. During an interview, on 4/27/22 at 3:28 p.m., trained medication aide (TMA)-A indicated awareness of R5's urinary incontinence issues, since admission on 1/12/22. TMA-A indicated since R5's admission to facility, R5 used pull-up briefs and prevail peri-pad during day, tabbed briefs at night. TMA-A indicated R5 was independent with toileting/hygiene needs during day, needed staff assistance at night. TMA-A stated R5 was recently hospitalized due to UTI sepsis, appears better now. When interviewed, on 4/27/22 at 3:42 p.m., registered nurse (RN)-C indicated R5 was recently hospitalized due to sepsis from UTI and heart irregularities. RN-C indicated was unaware if R5 got frequent UTI's, knew R5 had bladder scans completed approximately 2 months ago due to possible urinary retention. RN-C stated since R5 returned back to facility from hospitalization, staff are looking into obtaining a pure wick device to relieve R5's bladder retention, was used during recent hospitalization. RN-C indicated R5's history of urinary incontinence and retention was thought to have been contributed to UTI sepsis. RN-C reported being unaware of any monitoring or prevention measures in place for UTI in R5's care plan, indicated there should be with R5's history of urinary issues. During an interview, on 4/28/22 at 7:21 a.m., RN-B confirmed she completed R5's MDS assessment and CAAs, on 1/12/22, 4/6/22, and 4/15/22. RN-B stated she was the MDS coordinator, only one to complete all MDS assessments for each resident within facility.	F 636	documented symptoms for suspected and confirmed infections for completion and accuracy of Infection Monitoring Assessment every shift during the time frame of concern, for all residents x 1 quarter. Random audits will be completed thereafter. Audit results will be reviewed at QAA to ensure that consistent substantial compliance has been achieved. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 7/5/2022.	

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F 636	Continued From page 6 RN-B verified R5's CAAs lacked analysis of pre-populated data from R5's MDS, as well as inaccurate assessment details. RN-B confirmed lack of analysis and inaccuracy of assessment details could potentially affect R5's care received adversely. When interviewed, on 4/28/22 at 8:47 a.m., the director of nursing (DON), verified importance of accurate MDS assessment and CAAs completion. DON confirmed lack of analysis and inaccuracy of assessment details could lead to adverse cares provided to residents. DON indicated need for further follow-up and re-education to be provided to MDS coordinator. Facility policy and procedure for comprehensive assessments was requested but not received.	F 636		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and	F 661		6/13/22

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PARKVIEW CARE CENTER - WELLS	55 TENTH STREET SOUTHEAST WELLS, MN 56097

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F 661	Continued From page 7 over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately complete reconciliation of medications upon discharge for 1 of 1 resident (R26) reviewed for discharge practices. Findings include: Review of the face sheet (undated) in the medical record indicated R26 was admitted to the facility on 12/30/21, and discharged on 1/29/22. Review of a physicians order dated 1/29/22, indicated if applicable, R26 may discharge home with medications. The order did not list the medications to be sent home with R26. Review of the current physicians orders dated 1/29/22, included: Novolog insulin, polyethylene glycol, senna, solfenacin succinate, thiamine, acetaminophen, aspirin, atorvastatin calcium, Basaglar KwikPen solution insulin, calcium carbonate, gabapentin and glucose tablet. Review of the discharge report and progress notes dated 1/29/22, did not include any documentation if medications had been sent	F 661	F661 Discharge Summary It is the facility's intent to comply with the regulation to provide a discharge summary for the transition of care. The corrective action taken for Resident 26 included a follow-up phone call. The resident was discharged home. The resident had no questions or concerns at the time of the follow-up call with facility staff. The facility identified that all residents were at risk of being impacted by not having a discharge summary provided to them at the time of discharge to help facilitate a successful transition post-discharge. All discharging residents have the right to receive a discharge summary. The measures that were put into place were to create, implement and educate staff on a Discharge Checklist. Staff education will be provided on the expectations for discharges including the assessment to be completed and necessary documentation. Education will be provided on the importance of these	

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F 661	Continued From page 8 home with R26. The report or the progress notes also did not list any medication or number of doses, that may have been sent with the resident or family. Interview on 4/27/22, at 2:30 p.m. registered nurse (RN)-B who is facility MDS coordinator, indicated she discharged R26 on 1/29/22. RN-B indicated she sent the current ordered medications home with the resident and family. RN-B confirmed she had not reconciled the medication, nor did she document the medication or doses sent with R26. Interview on 4/27/22, at 3:00 p.m. with the director of nursing (DON) confirmed per policy, R26's medications should have been reconciled, that included the list of medications as well as the doses sent home with the resident/family. Review of the facility policy Discharge with Medications dated 4/4/19, included the procedure for discharging a resident with medications. The procedure directed staff to obtain an order from the physician, that includes the release of medications upon discharge of a resident. This included the name of the medication and specific order on the order form. The licensed staff should verify medication labels for accuracy and reconcile. On the medication release form the licensed staff should document the medication and the number of doses that will be sent on discharge and have the resident or family sign.	F 661	steps to enhance patient-centered care and assist in a successful transition for the resident The licensed direct care staff at the time of discharge will be responsible to complete the above-referenced checklist, which will include reconciling medication at the time of discharge and indicating how many, if any, were sent with the resident, destroyed, or returned to the pharmacy, obtain necessary signatures from resident/representative at the time of discharge and completing the discharge assessment in the electronic medical records system, various members of the IDT including dietary, social service and MDS coordinator will also be responsible for certain portions of the discharge assessment. The facility will monitor this by completing audits. The DON and/or SSD and/or designee will audit discharge assessments and documentation for completeness for the next 5 discharges and then quarterly x 2 or until satisfied that the proper discharge process is being routinely completed. Audit results will be reviewed at QAA to ensure that consistent substantial compliance has been achieved. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		7/5/22

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F 684	Continued From page 9 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the necessary coordination of services between the facility and hospice agency was completed by reviewing and incorporating the plans for services provided by hospice for 1 of 1 resident (R23) reviewed for hospice. Findings include: R23's facesheet printed on 4/28/22, indicated R23 had a diagnosis of congestive heart failure (CHF) (when the heart cannot pump blood as well as it should). R23's significant change Minimum Data Set (MDS) assessment dated 3/16/22, indicated R23 was cognitively intact, had clear speech, was understood and could understand. R23's care plan had a problem focus dated 4/4/22, indicating R23 had a terminal prognosis related to a diagnosis of CHF, and a hospice provider was identified in the care plan interventions. According to a hospice agency note dated	F 684	F684 Quality of Care It is the facility's intent to comply with the regulation to provide quality care through coordination with Hospice services. The corrective action taken for Resident 23 is to create an independent physical chart specifically containing hospice information, to be housed at the resident□s nursing station. This chart contains the following information: hospice plan of care, current visit schedule, current visit note obtained via Epic, or another communication method with the hospice provider, at the time of the survey this was the only resident receiving hospice services, and no further corrective action regarding the quality of care related to hospice coordination of services was required. The facility identified that all residents receiving hospice services have the potential to be affected by this deficient practice. The measures that were put into place were an independent physical chart specifically containing hospice information for those receiving this service; this is to	

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F 684	Continued From page 10 3/24/22, and scanned into the EMR (electronic medical record), R23 would start hospice services on 3/30/22. During an interview on 4/25/22, 2:04 p.m., R23 stated she was on hospice; didn't know the name of the agency, but stated they came twice a week. R23 could not discern between care provided by facility staff or care provided by hospice staff. During an interview on 4/26/22, at 12:50 p.m., nursing assistant (NA)-A stated R23 was on hospice. Other than a nurse, NA-A was not sure who from the hospice agency visited R23, but was aware R23 did not receive baths from the hospice agency. During an interview 4/26/22, 2:06 p.m., licensed practical nurse (LPN)-A stated R23 was on hospice due to losing weight and having a nodule in her neck. LPN-A did not know which days hospice came to see R23, stating they had not received a schedule from the hospice agency. LPN-A did not know if there was a hospice plan of care, and placed R23's hospice folder on the desk for review. Upon review of the contents of the folder, there were no hospice visit notes, plan of care or hospice staff schedule. LPN-A stated those documents were usually there. LPN-A stated the hospice nurse talked to nursing staff before visiting R23 and again after visiting R23, but this communication was not documented for next shifts. LPN-A admitted she did not know how the hospice staff communicated their visit findings with the facility staff. During an interview on 4/26/22, at 2:33 p.m., registered nurse (RN)-D was aware that R23 recently started hospice services, but did not	F 684	be housed at the applicable nursing station. This chart should contain the following information: hospice plan of care, current visit schedule, current visit note obtained via Epic, or another communication method with the hospice provider. This practice is the expectation for all residents who receive hospice services going forward. Since the time of the survey, we have admitted an additional resident into hospice services utilizing the Plan of Correction put into place after the deficient practice was brought to the facility and hospice agency□s attention.`. Staff education was provided on how communication is maintained between hospice staff and facility staff, how to document that a visit has occurred or any changes made to medications or plan of care. Education will also be provided on why access to this information is important for maintaining patient-centered care. Direct care licensed staff and/or Nurse Manager will document in electronic medical records when a hospice visit occurs if changes were made, and any pertinent information that on-coming staff should be aware of. The SSD and/or Nurse Manager will verify that Hospice documents have been received in a timely manner and are accessible to direct care staff to ensure that necessary care is received by our residents receiving hospice care. If documents have not been received, SSD and/or Nurse Manager will obtain them from the hospice provider for placement in	

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F 684	Continued From page 11 know when hospice staff came to see R23. RN-D looked around the nurses station for a hospice visit calendar but couldn't find one. When asked how hospice staff communicated their visits with the facility staff, RN-D looked in R23's EMR and located some scanned hospice notes. RN-D could not say if staff looked at those notes or if all staff knew where to find them. RN-D was unaware if there was a hospice plan of care for R23 and could not locate one in the EMR or in R23's paper hospice folder. During an interview on 4/26/22, at 2:49 p.m., the director of nursing (DON) stated R23's hospice plan of care should be in the EMR, but was not able to locate it. The DON assumed the hospice staff schedule was posted at the nurses desk and was informed staff could not find it. The DON stated the hospice nurse reported off to the facility nurse after seeing R23, but that communication was not documented. The DON who was new to the facility, was not sure how the process worked with hospice, but stated she would expect to have the hospice schedule, plan of care and visit notes available for staff so they would know what to expect regarding hospice services for R23. During an interview on 4/27/22, at 1:52 p.m., registered nurse (RN)-B stated the hospice agency did send a schedule of when hospice staff were scheduled to visit R23, but that it was thrown away, adding the schedule indicated the days hospice staff were coming, but did not indicate which resident they were seeing. RN-B had not thought to contact the hospice agency about that. During a telephone interview on 4/27/22, at 2:11	F 684	the chart. The facility will monitor this by completing audits. The DON and/or designee will audit hospice clients' charts for completeness, including the recent plan of care and visit schedule, and review nursing documentation regarding hospice communication, resident(s) and/or responsible party will also be interviewed, and/or observed to ensure that the care being received is part of the coordinated plan of care weekly x 4 weeks and then quarterly x 2 or until satisfied that care is being sufficiently coordinated with the hospice provider routinely. Audit results will be reviewed at QAA to ensure that consistent substantial compliance has been achieved. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 7/5/2022.	

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F 684	Continued From page 12 p.m., hospice agency supervisor (HAS)-C stated R23 received hospice services from a nurse, a social worker and a Chaplin, and that whenever a hospice staff member visited R23, a hospice visit note was routed to the facility through EPIC (an electronic medical record system used by the hospice agency). HAS-C stated in addition to the initial, admission hospice plan of care, the plan of care was updated every 14 days and routed to the facility via EPIC. HAS-C stated the hospice visit schedule was also routed monthly through EPIC. During record review, hospice visit notes in facility EMR included the following: --Nurse visit notes from 4/13/22 and 4/20/22. HAS-C stated there should be a note from 4/5/22. --Social worker visit notes from 4/4/22 and 4/6/22. --Chaplin visit note from 3/31/22. HAS-C stated there should be a note from 4/12/22. During an interview on 4/28/22, at 9:05 a.m., RN-B stated the hospice agency routed visit notes to the facility via EPIC and those notes automatically printed off on the facility fax machine. The faxed notes where then placed in a bin in the social workers office to be scanned into the facility EMR. RN-B admitted the notes were not scanned into the EMR right away and could remain in the bin for a few days. RN-B could not account for the visits identified by the hospice agency that the facility should have received; stating it was possible they were accidentally discarded. RN-B confirmed the facility did not have a hospice plan of care for R23. During an interview on 4/28/22, at 12:51 p.m., RN-B stated she received an April hospice schedule from the hospice agency. Upon review of the schedule, R23's name was prominently listed at the top of the 30-day calendar. RN-B	F 684		

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F 684	Continued From page 13 stated staff threw this schedule away in the past and did not know why. RN-B stated she would post it at the nurses station. During an interview on 4/28/22, at 1:15 p.m., the DON was informed of findings. The DON stated collaboration with hospice agencies was important to ensure resident wishes were carried out at the end of life. Based on conversations with facility staff, the DON stated she had already started looking at a way to audit hospice residents to ensure hospice agency information is present and available to the nursing staff. Facility policy on operationalizing the services of the hospice agency (not the agreement with the hospice agency) was requested; but the facility did not have one.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		6/13/22

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F 688	Continued From page 14 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate treatment, services, and assistance to maintain and/or prevent further decline in range of motion (ROM) ability were provided for 2 of 2 residents (R18 and R24) reviewed for mobility. Findings include: R18's quarterly Minimum Data Set (MDS) assessment dated 3/2/22, identified R18 had intact cognition, limited ROM to left lower extremity (LLE), no restriction to upper extremities (UEs); required extensive assist of 1 with activities of daily living (ADL) including bed mobility, transfers, locomotion, dressing, toileting, personal hygiene, and used a wheelchair for mobility. The MDS further indicated R18 was on a scheduled pain medication regimen and was not receiving physical therapy (PT), occupational therapy (OT), or restorative nursing services. R18's admission face sheet, printed on 4/26/22, identified diagnosis list to include; hemiplegia affecting left non-dominant side (paralysis of one side of body) following cerebral infarction (stroke), chronic obstructive pulmonary disease (lung disease causing difficulty breathing), obesity, muscle weakness, unsteadiness on feet, ataxia (impaired balance), and malaise (fatigue). R18's care plan, printed on 4/26/22, indicated restorative nursing: active ROM program while sitting in wheelchair. R18's active ROM program consisted of exercises including, using resistance band for bilateral upper extremities (BUEs);	F 688	F688 Increase/Prevent Decrease in ROM/Mobility It is the facility□s intent to comply with the regulation to implement interventions to help residents maintain or improve their range of motion The corrective action taken for R18 and R24 is to complete a therapy reevaluation to gauge the current level and appropriateness of a ROM plan at this time. If a new plan is recommended staff will be provided education on the resident-specific plan. Staff are scheduled to be educated on how to complete and document ROM as per the frequency indicated in the current plan of care. The facility identified that all residents are at risk for harm due to a lack of Range of Motion being provided to them as designated by the plan of care and therapy recommendations. The measures that were put into place were by 6/13/2022 all staff who are responsible for the Range of Motion (ROM) will be educated on the need to follow the individualized restorative nursing program regarding performing ROM exercises as outlined in the plan of care and should entries/interventions need to be no longer relevant, to report those changes immediately to the DON or designee who will update the plan of care at that time. The policy and procedure on the range of motion will be reviewed with all staff. All resident charts will be	

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F 688	Continued From page 15 upward pull, downward pull, upward diagonal, outward pull, outward rotation, overhead pulldown; forward punch, elbow bends, and elbow extension. Each exercise 15-20 repetitions, completed to each upper extremity. Lower extremities all sitting; toe taps, heel raises, marches, kicks, pillow squeeze, butt squeezes, knees apart. Each exercise 20 repetitions, completed to each lower extremity. R18's care plan indicated active ROM exercises should be completed am/pm care daily. OT exercise sheet, identified as; Resistive Band Exercises, dated 7/01. Exercises to be completed to BUE's included upward pull, downward pull, upward diagonal, outward pull, outward rotation, overhead pulldown, forward punch, elbow bends, elbow extension; 15-20 repetitions to be completed for each exercise; times per day not indicated. PT exercise sheet identified as, Lower Extremity Strengthening Exercises-Sitting, undated. Exercises to be completed to bilateral lower extremities (BLEs) included toe taps, heel raises, marches, kicks, pillow squeeze, butt squeezes, knees apart. 15 repetitions, 1-2 times each day, were to be completed for each exercise performed to BLEs. Nursing aide daily care sheet, identified as Nursing Roster East, indicated R18 had ROM to complete, but did not specify the types of exercises, repetitions, times per day to be completed. OT progress and discharge summary, dated 6/30/21, included home exercise program (HEP); R18 required staff assistance to complete	F 688	reviewed for similar occurrences and an order will be obtained to complete a therapy reevaluation to gauge the current level and appropriateness of the ROM plan at this time. Once completed, plans will be reviewed by MDS Coordinator, DON, and/or designee, plans will flow to CNA tasks to sign off in electronic medical records, and licensed staff will be responsible for following up to ensure completion. Plans will be documented in easy-to-follow step-by-step instructions, clarified with therapy. The expectations of the facility for the ROM program moving forward will be reviewed with the Therapy Department. The facility will monitor the range of motion audit documentation. The DON and/or designee will conduct audits weekly x 4 weeks, and then quarterly x 2 or until satisfied that ROM programs are being routinely completed. Audit results will be reviewed at QAA to ensure that consistent substantial compliance has been achieved. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	

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F 688	Continued From page 16 mobilization and massage program accurately, continue exercises during group exercises with activities 3 times per week. Therapy recommendations not addressed per orders or care plan upon document review. During an observation and interview on 4/25/22, at 6:02 p.m., R18 was visualized while sitting upright in wheelchair, right elbow appeared stiff and bent inward across body. R18 was observed to be able to raise RUE 3/4 way straight up, able to extend RUE outward 3/4 way. No concerns noted upon visualization or R18's report to right hand. R18 indicated LLE feels numb, sometimes weak, and gives out; "once in a blue moon" R18 indicated mobility issues occurred after stroke approximately 8 years ago, denied any new or worsening changes in mobility. R18 indicated sometimes having no pain to moderate pain to RUE, on a scheduled pain medication regimen and feels pain medication regimen is sufficient in reducing pain. R18 indicated having massage and mobilization to RUE to reduce pain and maintain mobility, has not had since last OT session. R18 reported since admission, worked with PT and OT approximately 2-3 times, used to do ROM with resistance band and staff assistance. R18 stated staff had not provided any exercise therapy for past 1-2 months. When interviewed, on 4/26/22 at 1:01 p.m., nursing aide (NA)-B indicated being aware of R18's exercise therapy. NA-B reported R18's exercises consisted of performing finger touches, touching fingers to each other; and for LLE toe tapping on floor. NA-B indicated she thought R18's exercises were to be completed 3 times each day. NA-B indicated R18 had a resistance band in room, had never seen R18 use	F 688		

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F 688	Continued From page 17	F 688		

resistance band. NA-B was observed to pull up NAs charting to be completed through electronic medical record (EMR) system, indicated orders for restorative nursing program to be completed by nursing aides, included resistance band use for bilateral upper extremity therapy. Restorative nursing exercises for NAs to complete for R18 did not indicate type of exercises needing to be completed, repetitions, times per day; did require NAs to mark completed when restorative nursing exercises had been performed and to indicate how many minutes were spent with R18 to complete exercises. NA-B indicated R18 was compliant with performing restorative nursing exercises when asked per NAs.

During an interview, on 4/26/22 at 1:09 p.m., NA-A indicated being familiar with R18's cares, had worked with R18 for past 6-7 months. NA-A indicated R18's exercise therapy included finger touches and toe taps; completes exercises for 10-15 minutes once per day. NA-A indicated R18 was independent in completing therapy exercises, just needed reminders. NA-A indicated not being aware of any new changes in exercise regimen.

When interviewed, on 4/26/22 at 1:17 p.m., licensed practical nurse (LPN)-B indicated working at facility for 2 years, was familiar with R18's care needs. LPN-B indicated being unaware of R18's therapy exercises, stated "I'm not sure what therapy exercises resident is supposed to do. I just pass her pills and answer her call-light." LPN-B indicated therapy books are located on each resident wing, R18's therapy plans if she had any, could be found in a red binder. LPN-B did look up R18's care plan, indicated restorative nursing program for active

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F 688	Continued From page 18 ROM to RUE and LLE, included resistance band therapy; aides completed. LPN-B stated after review of EMR, could not find an order or anything care planned for RUE mobilization and massage; would need to check further into that. LPN-B indicated she would expect NAs to check care plan prior to providing cares and follow per orders. During an interview, on 4/26/22 at 1:28 p.m., NA-C indicated working at facility for 2 years, was aware of resident care needs with therapy exercises. NA-C stated R18 had an exercise program sheet in her room and was supposed to do exercises independently. NA-C indicated exercise regimen for R18 included bilateral arm stretches and moving lower extremities around while sitting in wheelchair. NA-C stated she was unaware of any resistance band exercises for R18. NA-C indicated not being aware of any new or worsening changes in mobility or ROM for R18. When interviewed, on 4/26/22 at 01:37 p.m., physical therapy aide (PTA)-A; indicated R18 was last evaluated by PT on 5/8/21 and at that time R18's transfers continued to fluctuate from 1-2 assist, needed to use E-Z stand; did not progress and was at maximal functional potential. PTA-A indicated R18 was to remain in skilled nursing facility (SNF) with ongoing assist from nursing staff for mobility with LE HEP for strength and coordination. PTA-A stated occupational therapy (OT) was out office. PTA-A looked through OT progress notes, last OT note was from discharge on 6/30/21; OT indicated at that time R18 would be discharged due to decreased pain and increased functional use of the RUE, R18 encouraged to continue exercises during group	F 688		

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F 688	Continued From page 19	F 688		

exercises with activities staff 3 times per week. PTA-A indicated being unaware of any other exercise regimens recommended per OT and to contact OT staff to further discuss.

During phone interview, on 4/26/22 at 2:49 p.m., OT-A indicated R18 was to complete whatever activity was offered during group activity with activities department 3 times per week. OT-A indicated being aware of OT recommendations for RUE mobilization and massage based on previous OT notes, but that occurred prior to OT-A coming back from maternity leave. OT-A indicated being unaware of resistive band therapy, may have been recommended by OT while OT-A was out on maternity leave, and to contact OT-B for further information.

When interviewed, on 4/26/22 at 2:01 p.m., director of nursing (DON); indicated after review of R18's care plan, all nursing staff should be assisting resident with resistant band therapy, as well as other positional therapies. DON indicated R18's functional status should be assessed quarterly and with any significant change, nursing staff should be following care plan recommendations. DON indicated licensed nursing staff are responsible to ensure care plans are being followed and to oversee aides' completion of assigned tasks. DON verified R18's care plan recommendations do not match NA assignment tasks listed and all nursing staff should be completing R18's exercise therapy regimen per PT and OT orders. DON verified that R18 had not been receiving appropriate therapy services.

During a phone interview, on 4/26/22 at 6:23 p.m., OT-B indicated working with R18 during

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F 688	Continued From page 20 OT-A's absence. OT-B stated she recommended on 6/24/21, a soft tissue passive range of motion (PROM) program, along with massage to RUE for pain; staff needed to be provided education on soft tissue PROM and massage to RUE first. OT-B indicated she had communicated to OT-A to follow up on soft tissue PROM and massage to RUE, along with needing to educate nursing staff on soft tissue PROM and massage to RUE. OT-B indicated being unaware that recommendations for soft tissue PROM and massage to RUE were not followed up on, nor education to nursing staff provided. OT-B indicated importance of R18 receiving soft tissue PROM and massage to RUE to not lose mobility had; needed to be re-evaluated per OT. OT-B verified OT department should have ensured R18 continued to receive soft tissue PROM and massage to RUE, along with education being provided to nursing staff. When interviewed, on 4/28/22 at 7:21 a.m., RN-B indicated therapy department gave orders for R18's restorative nursing program originally on 4/22/20. RN-B stated therapy department provided restorative nursing order and exercise regimen handout to charge nurse on day when ordered and provided a copy of restorative nursing order to her. RN-B indicated therapy department explained to both charge nurse and her what needed to be completed for R18's exercise regimen. RN-B stated charge nurse should have put the order and exercise regimen handout into unit therapy book, explained to aides working on floor what was expected for R18's continued therapy needs. RN-B indicated being responsible for placing therapy orders into EMR and updating care plan. RN-B stated NAs were to review R18's care plan for any new orders or	F 688		

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F 688	Continued From page 21 changes, signing off on daily task list assignments once completed. RN-B indicated nursing staff should be in residents' rooms when assisting and supervising exercise regimen; nursing staff should not walk into residents' rooms to advise them to complete exercise regimen independently, then leave room. RN-B reviewed R18's care plan, verified restorative nursing active ROM program exercise regimen had discrepancies related to times per day NAs were to complete exercises, no orders for massage or soft tissue PROM to RUE. RN-B indicated she needed to check further into issue. R24 R24's Significant change of status MDS assessment, dated 3/16/22, identified R24 had moderately impaired cognition. R24 had limited ROM to all extremities requiring extensive assist of 2 with bed mobility, transfers, toileting; extensive assist of 1 with dressing, personal hygiene, and locomotion. R24 used wheelchair, was non-ambulatory. R24's admission face sheet, printed on 4/28/22, identified diagnosis list to include; dementia (brain disorder causing memory loss and impaired judgment), osteoarthritis (condition causing loss of tissue covering bone) of knee, hereditary and idiopathic (unknown cause) neuropathy (condition causing nerve damage), age-related osteoporosis (weak, brittle bone disorder), carpal tunnel (pinched nerve of hand/arm) of both upper limbs, intervertebral disc degeneration of lumbosacral region (wearing of lower back), tremor (involuntary shaking), and abnormality of gait and mobility.	F 688		

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F 688	Continued From page 22 R24's care plan, printed on 4/28/22, indicated restorative nursing: active ROM program while sitting in wheelchair. R24's active ROM program consisted of exercises including, using resistance band for bilateral upper extremities (BUEs); upward pull, downward pull, upward diagonal, outward pull, outward rotation, overhead pulldown; forward punch, elbow bends, and elbow extension. Each exercise 15-20 repetitions, completed to each upper extremity. Lower extremities all sitting; toe taps, heel raises, marches, kicks, pillow squeeze, butt squeezes, knees apart. Each exercise 20 repetitions, completed to each lower extremity. R24's care plan did not indicate how often active ROM exercises should be completed each day. R24's care plan further indicated need for cueing, reorienting, and supervision due to impaired cognitive function. OT progress and discharge summary, dated 7/17/20, indicated R24 had gains in strength and endurance, impacted ability to perform toilet transfers with a reduction in assist to standby assist (SBA); due to achieving high level of independence, R24 would be discharging from skilled OT services. Therapy staff developed and implemented a BUE HEP for R24 to continue to complete with nursing staff upon discharge from OT services. OT plan of care, dated 2/11/22, indicated R24 received an evaluation for proper postural alignment and new wheelchair fitting, required services through 3/24/22; all extremity mobility needs, and continued exercise regimen had not been addressed.	F 688		

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F 688	Continued From page 23 During observation and interview, on 4/27/22 at 1:30 p.m., NA-C indicated being aware of R24's exercise therapy. NA-C stated exercises were to be completed once daily; had resistance band exercises for BUE, along with an exercise regimen for BLE. NA-C indicated R24 had copy of exercise therapy needed in her room. NA-C stated to R24 upon entering R24's room, "where are your exercise sheets, the ones for your hands and legs?" R24 didn't respond. NA-C opened R24's dresser drawer, pulled out a manilla folder, removed copies provided for LE HEP exercises and UE resistance band exercises. A green colored resistance band was observed folded inside of manilla folder. NA-C was asked if R24 had been completing exercise regimen, NA-C stated regarding R24, "You just have to tell her, and she'll do them." When interviewed, on 4/27/22 at 1:43 p.m., NA-D indicated working at facility occasionally, not completely sure of R24's care needs, would ask nursing staff and look in care plan for further direction. NA-D reviewed EMAR for R24's exercise orders, unable to determine type of exercise and amount of time to be spent to complete therapy regimen. NA-D reviewed unit therapy book found copy of exercise regimen for LE HEP nothing for UE. NA-D reviewed care plan in EMR, indicated restorative nursing program to be completed each shift; use of resistance bands for BUE's, BLE HEP. NA-D stated daily nursing aide task sheet, labeled nursing roster east, indicated R24 had ROM listed to complete; did not provide any further exercise information. During an interview, on 4/27/22 at 2:17 p.m., RN-C indicated working at facility casually, for	F 688		

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approximately 1 month. RN-C reported being unaware if R24 had an exercise program, reviewed care plan, indicated nursing aides complete exercise therapy regimen. RN-C stated being unsure how to look up information to oversee nursing aide assigned task completion for shift, would need to ask DON.

When interviewed, on 4/28/22 at 7:21 a.m., RN-B stated therapy department provided restorative nursing order and exercise regimen handout to charge nurse on day when ordered and provided a copy of restorative nursing order to her. RN-B indicated therapy department explained to both charge nurse and her what needed to be completed for R24's exercise regimen. RN-B stated charge nurse should have put the order and exercise regimen handout into unit therapy book, explained to aides working on floor what was expected for R24's continued therapy needs. RN-B indicated being responsible for placing therapy orders into EMR and updating care plan. RN-B stated NAs were to review R24's care plan for any new orders or changes, signing off on daily task list assignments once completed. RN-B indicated nursing staff should be in residents' rooms when assisting and supervising exercise regimen; nursing staff should not walk into residents' rooms to advise them to complete exercise regimen independently, then leave room. RN-B reviewed R24's care plan, verified restorative nursing active ROM program exercise regimen had discrepancies related to type of exercises performed, repetitions, times per day NAs were to complete exercises. RN-B stated she needed to check into this further.

When interviewed, on 4/28/22 at 10:30 a.m., DON indicated after review of R24's care plan, all

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F 688	Continued From page 25 nursing staff should be assisting resident with resistant band therapy, as well as other positional therapies. DON indicated R24's functional status should be assessed quarterly and with any significant change, nursing staff should be following care plan recommendations. DON indicated licensed nursing staff are responsible to ensure care plans are being followed and to oversee aides' completion of assigned tasks. DON verified R24's care plan recommendations do not match NA assignment tasks listed and all nursing staff should be completing R24's exercise therapy regimen per PT and OT orders. DON verified that R24 had not been receiving appropriate therapy services. Facility policy titled, "Prevention of Decline in Range of Motion," revised 11/17, indicated policy explanation and guidelines consisting of; assessment for range of motion, appropriate care planning, and preventative care. Assessment for range of motion included; licensed nurses would assess a resident's range of motion on admission/readmission, quarterly, and upon a significant change; residents who exhibited limitations in range of motion, initially and thereafter, would be referred to the therapy department for a focused assessment of range of motion; nursing assistants would report any significant changes in range of motion to resident's nurse; assessment should include identified risks which could impact resident's range of motion including, but not limited to; immobilization, neurological conditions causing functional limitations, any condition where movement may result in pain/spasms/loss of movement. Appropriate care planning consisted of; facility would provide interventions, exercises, and/or	F 688		

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F 688	Continued From page 26 therapy to maintain or improve range of motion; facility would provide treatment and care in accordance with professional standards of practice including; appropriate services (specialized rehabilitation, restorative, maintenance); assistance as needed (active assisted, passive, supervision); care plan interventions would be developed and delivered through facility's restorative program; interventions documented on resident's person centered care plan and included; type of treatments, frequency and duration of treatments, measurable objectives, resident goals; nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions; modifications to the plan of care will be made as needed. Preventative care included; staff educated on risk factors for decline in ROM; immobilization, deformities arising out of neurological deficits, pain/spasms/mobility associated with arthritis and late state Alzheimer's disease, or other condition; staff education provided on basic, restorative nursing care including; maintaining proper positioning and body alignment, encouraging residents to remain active and assist with any exercises according to care plan; assisting residents with range of motion exercises; residents will receive services from restorative aides or therapists as needed.	F 688		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		6/13/22

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F 756	Continued From page 27 §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: Based on interview and document review the consultant pharmacist failed to identify missing drug level monitoring for 1 of 6 residents (R18); whom were reviewed for unnecessary medications, psychotropic medications, and	F 756	F756 Drug Regimen Review, Report Irregular, Act-On It is the facility's intent to comply with the regulation to provide a comprehensive pharmacy review for evaluating the	

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F 756	Continued From page 28 medication regimen review. Findings include: R18's admission face sheet, printed on 4/26/22, identified R18 had a diagnosis of vitamin D deficiency (nutrient needed for building and maintaining healthy bones). R18's physician orders, printed on 4/26/22, indicated R18 received vitamin D3 1000 IU (units) by mouth once daily for vitamin supplement therapy. R18's laboratory results requested, received on 4/28/22, did not indicate vitamin D level had been drawn. No current vitamin D level was found in the medical record. R18's consultant pharmacist recommendations from 4/2/21 until 4/7/22 were reviewed. No recommendation for a vitamin D level was made by the consultant pharmacist. During phone interview, on 4/27/22 at 10:15 a.m., the pharmacist stated R18's vitamin D level had not been drawn per their records in over 1 year, her expectation would have been to have a vitamin D level drawn at least yearly, and pharmacist should have requested a vitamin D be completed for R18. When interviewed, on 4/28/22 at 8:47 a.m., the director of nursing (DON) stated the pharmacist should have identified the missing vitamin D level, requested a vitamin D level be completed for R18. Facility policy titled Medication Regimen Review,	F 756	resident's response to medication therapy. The corrective action taken for Resident 18 is to obtain laboratory monitoring for Vitamin D deficiency. An order for the appropriate lab has been requested from the provider. The facility identified that lack of laboratory monitoring was an isolated event. No other residents are at an immediate risk. The measures that were put into place were to review all medical records for the same or similar occurrences. If applicable, we will work with the provider to obtain the necessary lab for monitoring and verify the diagnosis is correct. When a vitamin deficiency diagnosis is noted, routine lab monitoring will be requested at the time of admission or addition of diagnosis. Staff education will be provided on the importance of lab monitoring for necessary medications related to deficient vitamin diagnosis. Licensed floor staff and/or Nurse Manager and/or MDS Coordinator will be responsible for ensuring that when a vitamin supplement is taken related to a vitamin deficiency diagnosis all pertinent labs for monitoring are also ordered and obtained. The deficient practice was reviewed with the consulting pharmacist at the May 19th QAA meeting to ensure medications are appropriately monitored and follow-up occurs when medications require lab monitoring. The facility will monitor pharmacy review audits. DON, MDS coordinator, and/or designee will audit documentation to	

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F 756	Continued From page 29 dated 4/1/19, included; the consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly, the medication regimen review includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning, in performing medication regimen reviews the consultant pharmacist incorporates federally mandated standards of care, the consultant pharmacist identifies irregularities through a variety of sources including the resident's clinical record, pharmacy records, and other applicable documents. Review of the policy, Medication Monitoring and Management, dated 4/1/19, included; the consultant pharmacist evaluates medication administration to verify that the resident has received medications in accordance with the prescriber's orders and facility policy, procedures are monitored and intervention is provided when necessary, reconciliation of observation with prescriber's orders including identification of any orders omitted and verification of current orders for medication given.	F 756	support the necessity of ongoing utilization of vitamin supplements. These audits will be done for any new resident who admits on and/or a current resident who is started on a vitamin that requires laboratory monitoring due to a deficiency diagnosis x 1 quarter. Audit results will be reviewed at QAA to ensure that consistent substantial compliance has been achieved. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
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	F 758		6/13/22

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PARKVIEW CARE CENTER - WELLS	55 TENTH STREET SOUTHEAST WELLS, MN 56097

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F 758	Continued From page 30 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §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:	F 758		

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F 758	Continued From page 31 Based on observations, interview and document review, the facility failed to implement individualized non-pharmacological interventions and ensure justification for 2 newly ordered psychoactive medications, and for a current psychoactive medication that had been increased, for 1 of 5 residents (R16) who was admitted to the facility 7 weeks prior to the additional orders. Finding include: R16 was admitted on 2/24/22. R16 diagnosis (identified on the admission record) dated 2/24/22, included; dementia without behavioral disturbances and generalized anxiety disorder, R16's significant change Minimum Data Set (MDS) assessment dated 3/31/22, identified R16 as having a brief interview for mental status (BIMS) score of "0" (severe cognition impairment). R16 required extensive assistance with activities of daily living (ADL's). The MDS identified R16 as having no mood or behaviors during the assessment period. R16 received 7 days of antianxiety medications and 7 days of antidepressant medications. R16's care plan dated 4/27/22, identified having extreme high anxiety. These behaviors cause the resident to make noises and wheel up and down the hallways, and at times in to other residents rooms. R16 at times will become verbally and physically aggressive towards staff with cares, yell out and cry. Interventions listed; administer medications as ordered, positive interactions, explain details before cares, offer food and drink, music, stuffed puppy, toilet and structured activities. Monitor for drug effectiveness and dose	F 758	F758 Free from Unnecessary Psychotropic Medications/PRN Use It is the Facility□s intent for the resident□s drug regimen to be free from unnecessary psychotropic drugs. The corrective action taken for the R16 medication regime has been reviewed with the physician and pharmacist. No changes were made at the time of the review, monitoring of mood and behavior will continue. The facility identified that all residents have the potential to be impacted by this deficient practice. A review of all residents receiving psychotropic medications will be completed by 06/13/2022. The measures that were put into place were to educate licensed nursing staff on the Use of Psychotropic Medication policy, as well as education on supporting documentation when psychotropic medications are necessary, and the use of non-pharmaceutical interventions. A copy of the facility policy, as well as a copy of the regulation 483.45 (C)(3) (e) (1)-(5) relating to Psychotropic drugs, was provided to the physician and consultant pharmacist for reference on 5/27/2022. The facility will monitor DON and/or designee will audit any resident's newly prescribed psychotropic medication or adjustments made to a currently prescribed psychotropic medication weekly x 4 weeks, and then quarterly x 2, or until satisfied that deficient practice is in greater compliance. Audit results will be reviewed at QAA to ensure that consistent substantial compliance has been achieved.	

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F 758	Continued From page 32 reduction reviewed at least every 6 months. R16's progress note dated 2/21/22 (admission H&P) indicated diagnosis of anxiety and dementia without behavioral disturbances R16 was admitted from an assisted living facility. R16 has had multiple fractures of the hips and pelvis in the past 5 years, from falls. R16 is wheelchair bound. R16 is calm and stable currently, but does get anxious at times. R16 has exhibited anxiety episodes all of her life. R16 was admitted with orders that included Lexapro (used for depression) 20 mg daily and Trazodone (used for depression/sleep) 25 mg at bedtime. Review of a physician progress note dated 3/11/22, included an order for Cymbalta (used for depression/ nerve pain) 40 mg daily. The note indicated per family request. No additional notes documented. Review of a physician progress note visit dated 3/17/22, indicated R16 has adjusted well to nursing home (NH) placement. No concerns expressed by the resident or the nursing staff during the visit. R16 is receiving Trazodone 25 mg daily, Cymbalta 40 mg daily and Lexapro 20 mg daily, at the current time. Continue with current medications. Review of a physician order dated 4/19/22 per fax, included an order for Buspar (used for anxiety) 10 mg bid and increase Trazodone from 25 mg at bedtime to 50 mg at bedtime. The fax note indicated the medications were increased, due to increased anxiety and yelling out. Review of the progress notes for the month of 4/22 included only 4 episodes of yelling/crying.	F 758	The audits will be reviewed and evaluated by the Interdisciplinary Team (IDT), and QAA to determine substantial compliance. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	

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Review of the progress notes from 2/24/22 (admission) to 4/27/22. The notes included 18 episodes of yelling and crying for the month of 3/22 and 4 times for the month of 4/22. R16 was redirectable during these behavioral episodes, with non-pharmacological interventions and lasted for short periods of time.

Review of a progress note date 4/21/22 by the provider for a NH visit indicated the resident had no concerns and neither did the staff. The residents problem list included dementia without behavioral disturbances and anxiety. The medications list did not include the updated changes that occurred on 4/19/22. The orders that the provider included in his progress notes as current and signed and dated for 4/21/22. The progress note did not address the psychoactive medications, nor the use of the medication and outcome.

Review of the current physicians orders dated 4/27/22, included Trazodone 50 mg daily, Lexapro 20 mg daily, Buspar 10 mg 2 times a day (BID) and Cymbalta 40 mg daily.

R16's Consulting Pharmacist's Medication Review dated 3/31/22, indicated R16's medication list was reviewed. Documentation did not include any recommendations. The consulting pharmacist had not done the 4/22, review yet. During the 3/31/22, review R16's Psychoactive medication orders included Lexapro 20 mg daily, Trazodone 25 mg at bedtime. R16's new medication order for Buspar and increase in Trazodone were ordered after 3/31/22.

Observation on 4/25/22, from 2:00 p.m. to 4:00

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F 758	Continued From page 34 p.m. from 6:00 to 7:00 p.m. R16 was sitting in the hallway outside her room. R16 was holding a stuffed puppy and listening to soft music. R16 was heard calling out "help" twice, but otherwise was observed to be calm and relaxed. Staff were observed to interact with R16 while passing by her in the hallway. R16 was not interviewed due to decline in cognition and not understanding. Interview on 4/25/22, at 6:00 p.m. registered nurse (RN)-C indicated R16 becomes anxious and fidgety and is difficult to calm her down. RN-C stated R16 will yell out for no apparent reason and cry out loud. RN-C indicated staff provide R16 with her stuffed puppy and music, which calms her down. RN-C indicated R16's mood and behaviors seem to be better since admission. Observation on 4/26/22, from 9:00 a.m. to 11:00 a.m. and from 1:30 p.m. to 3:00 p.m. R16 was observed wheeling self in the hallway and in her room. Staff were noted to acknowledge the resident and offer items she enjoys (stuffed puppy, music). R16 was relaxed and calm when observed during these times. During phone Interview on 4/26/22, at 1:00 p.m. the facility consulting pharmacist indicated he had not completed R16 medication review yet for 4/22. The consulting pharmacist stated he had not been aware of the increase in R16's psychoactive medications. The consulting pharmacist indicated he would have recommended a decrease in the psychoactive medication, and would not have recommenced an increase or adding any additional medication. The consulting pharmacist indicated if the current medication was not benefiting the resident, he	F 758		

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F 758	Continued From page 35 would recommend a decrease, as the resident was currently taking other psychoactive medications. The consulting pharmacist also added, he would recommend adjusting 1 psychoactive medication at a time. The pharmacy consultant further stated it would be difficult to know which medication is effect when adjusting or adding more than 1 medication at a time. Observation on 4/27/22, at 10:00 a.m. R16 was observed to be calm and relaxed. R16 was in her room playing with her stuffed puppy and mumbling to self. R16 just smiled at the surveyor when attempting conversation. Interview on 4/27/22, at 1:00 p.m., the facility minimum data set (MDS) coordinator, verified since R16's admission on 2/24/22, 2 new psychoactive medication had been been ordered and a current psychoactive medication had been increased. The MDS coordinator also confirmed the current MDS did not include any exhibited mood or behaviors. The depression scale was assessed as a "0" (which means no depression). Interview on 4/26/22, at 2:00 p.m., the facility director of nursing (DON), confirmed the above documentation. The DON indicated she did not understand why the provider would add or increase 2 psychoactive medications at the same time. The DON also confirmed the documentation for non-pharmacological interventions implemented for R16, had been working. Phone call place to R16's provider on 4/17/22, at 11:00 a.m. with no return call. Interview on 4/28/22, at 9:30 a.m. nursing assistant (NA)-D, NA-E and NA-F, all indicated	F 758		

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F 758	Continued From page 36 the identified non-pharmacological interventions implemented for R16 were effective. The NA's stated R16 will cry out or become anxious and fidgety, but often staff can calm her down with music and her stuffed puppy. The NA's indicated R16 is cooperative most of the time, but requires patience and direction Facility policy titled Use of Psychotropic Medication, dated 2021, directed; 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. 2. The indications for initiating, withdrawing, or withholding medications(s), as well as the use of non-pharmacological approaches, will be determined by: a. Assessing the resident's underlying condition, current signs, symptoms, expressions, and preferences and goals for treatment. b. Identification of underlying causes (when possible). 3. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/or representatives, other professionals, and the interdisciplinary team. 4. The indications for use of any psychotropic drug will be documented in the medical record. a. Pre-admission screening and other pre-admission data shall be utilized for determining indications for use of medications ordered upon admission to the facility. b. For psychotropic drugs that are initiated after admission to the facility, documentation shall	F 758		

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F 758	Continued From page 37 include the specific condition as diagnosed by the physician. i. Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed. ii. Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation. 5. Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. 6. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: a. Upon physician evaluation (routine and as needed), b. During the pharmacist's monthly medication regimen review, c. During MDS review (quarterly, annually, significant change), and d. In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		6/13/22

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F 812	Continued From page 38 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to date opened containers of food stored in one of three kitchen refrigerators, standup freezer, and walk-in freezer, failed to ensure expired food were identified and removed, failed to ensure walk-in freezer vent was in safe working condition and food was stored away from leaking vent. This had the potential to affect all 30 residents who were served food and beverages from the facility kitchen. Findings include: During interview and observation of kitchen on 4/25/22 at 12:54 p.m., with dietary director (DD), observed food items in the standup refrigerator, standup freezer, walk in refrigerator that were not dated or marked and/or were expired. DD indicated all kitchen staff were responsible for checking food for opened dates and expiration dates, all refrigerators and freezers should be gone through daily to check for expired or damaged food. DD indicated if any food or drink	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary It is the facility's intent to comply with the regulation to store, prepare, distribute and serve food in accordance with professional standards for food service safety The corrective action taken for 24 out of 24 residents is to ensure that opened containers of food are dated. Food is discarded according to state/federal guidelines and the facility's policy & procedure. No food is stored near the leaking ceiling vent until it can be repaired. The facility identified that all residents are at risk for potential harm when food is not appropriately stored, prepared, and served in a sanitary manner. The measures that were put into place are to utilize the dissolvable labels from our food vendor moving forward. The dietary department staff will be educated by June 2, 2022, on the policies and procedures to	

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F 812	Continued From page 39 is not dated when opened, it should be removed immediately. DD indicated all left-over prepared food and beverages when marked are good for 7 days from date opened. The following items were observed during tour: Stand-up refrigerator: 1.. Chocolate soy milk- 8 oz. unopened; exp date 3/18/22 2. Kemp's fat-free skim milk; 1/4 full; exp date 4/20/22 3. lettuce head; ½ remaining, observed turning brown in discoloration in center; unmarked/undated 4. cucumber; ¼ left-wrapped in saran wrap; unmarked/undated Stand-up refrigerator: 1. pickles; approximately ½ full; placed in facility plastic container, dated 4/16/22; no expiration date 2. sauerkraut; approximately ½ full; placed in facility plastic container, dated 4/9/22; no expiration date 3. sour cream; 4 oz. placed in facility plastic container; dated 4/9/22; no expiration date Stand-up refrigerator: 1. apple cider vinaigrette dressing; ¾ full; opened 9/27/21; no expiration date 2. french dressing; approximately ½ full; unmarked/undated 3. Maries country dijon honey mustard; approximately 1/4 full; exp date 1/9/22 4. Minors low sodium chicken base; 16 oz.; exp date 4/19/22 5. prunes in facility container; approximately ¼ full; opened 10-5-21; used by date labeled 4-5-22	F 812	ensure that food is discarded within 7 days of opening. All dietary staff will be educated by June 2, 2022, that food items are no longer to be placed on the top shelf so that air recirculation and short cycling do not occur in the walk-in freezer and temperature inconsistencies can be minimized. Maintenance ordered white epoxy paint and weather permitting, is planning to paint the roof area by the week of June 6th, 2022, to reduce the surface temperature that impacts the walk-in freezer seasonally as recommended by Cress the refrigeration repair vendor. All dietary staff will be educated by June 2, 2022, that no food item should be placed on the top shelf since condensation can occur during defrost mode. The Environmental Services Coordinator will be sealing the leaking vent with the repair leak sealer purchased on 5/25/2022. Daily audits will be performed by the Dietary Director or designee to verify compliance with the policy. The Dietary Director will add dating and discarding of food to the daily schedule of duties. The Dietary Director will ensure that staff is qualified to identify/log refrigerator and freezer temperature per state/federal guidelines and company policy & procedure. The dietary staff was educated on the process of communication and action regarding temperatures that were found to be out of compliance. All dietary staff will be trained on the facility□s policies and practice guidelines	

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F 812	Continued From page 40 Stand-up freezer: 1. doughnuts in clear plastic bag; approximately 5; unmarked/undated 2. rhubarb pieces in ziplock bag; approximately ¼ full; unmarked/undated 3. Eggs; in plastic facility container covered with lid; approximately eight in count; had an expiration date of 3/22/22; sitting on top of pushcart. 4. omelets; in clear, open plastic bag; approximately 8; freezer burn observed; unmarked/undated Walk-in freezer: 1. angel food loaf; full; unmarked/undated 2. bagels in plastic bag; approximately 2; unmarked/undated 3. ring of bologna; full ring; appeared freezer burned; unmarked/undated 4. pork ribs; 1 package; unmarked/undated Walk-in freezer ceiling vent: During observation and interview of walk-in freezer, on 4/25/22 at 2:01 p.m., ceiling vent noted to have icicles hanging downward towards boxes of food on shelving. Two spots of ice patches, approximately 3cm in diameter each, noted on flooring. DD indicated awareness of water leaking from ceiling vent, especially when the weather is rainy and windy. DD indicated leaking from ceiling vent has been an ongoing issue, she stated someone was there to fix issues with walk-in freezer approximately 1 month ago. When interviewed, on 4/25/22 at 3:21 p.m., DD indicated when food and beverage items are delivered to facility, staff placed a date on food items to know which items are newer vs. older, as	F 812	for maintaining proper food storage by June 2, 2022. In-service training included observation of each employee performing the procedure and verifying dates on stored food. A Validation Checklist was completed for each dietary employee to determine if the employee was proficient in storage criteria, dating, and disposing of expired food. Findings were reviewed with each employee. Corrective action and/or education will be provided. The facility will monitor food storage and safety audits. The dietary director will complete audits weekly for 3 months. Then monthly for 6 months. The Maintenance Coordinator will be responsible to ensure weekly recommendations from the refrigeration vendor are implemented and adhered to. Maintenance will keep a record of these inspections and results to monitor for any further signs of equipment failure confirming that condenser coils are clean and the food products are away from the grille so that air recirculation and short cycling do not occur. The audits will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine substantial compliance. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	

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F 812	Continued From page 41 older food items are to be used up first. DD indicated when food items were opened, staff would write "open" and the date, to indicate when staff needed to discard items. DD indicated being a newer employee to facility, was unaware of facility's process for when food items should be discarded; thought within 7 days of opening if going by previous employer's policy, needed to get further clarification from management team and review facility policy. An observation of walk-in freezer and interview occurred on 4/28/22 at 1:40 p.m., with M-A, DD, and RN-A. M-A, DD, RN-A observed ceiling vent in walk-in freezer; all agreed noting icicles hanging down over frozen food on shelving, ices chunks on food boxes, ice chunks in between shelving where food boxes were stored. RN-A indicated food boxes in area of shelving, underneath leaking ceiling vent, should be moved away from leaking ceiling vent to prevent any possible food contamination. M-A indicated in meantime until someone can look at ceiling vent, a bucket would be placed under ceiling vent to catch excess water/condensation/icicles. When interviewed, on 4/28/22 at 2:28 p.m., M-A indicated there had been problems with walk-in freezer since 8/2021, had 2 different refrigeration companies look at leaking from ceiling vent and temperature control issues. M-A provided invoice records completed for walk-in freezer. Invoice from Cress Refrigeration provided to facility indicated services completed on 8/11/21 for warm temperature to walk-in freezer; walk-in freezer running warm at 18 degrees Fahrenheit, temperature sensor was behind strip curtain causing high reading, thermometer sensor moved	F 812		

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	245436	A. BUILDING _____ B. WING _____	04/28/2022

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F 812	Continued From page 42 out of strip curtain, thermostat lowered. Cress Refrigeration recommended on 9/4/21 invoice for facility staff to clean condenser coil, paint black roof white to reduce roof surface temperature, keep product as far away from grille as possible to avoid air recirculation and short cycling. Invoice from Cress Refrigeration provided to facility indicated services completed on 10/16/21 for failed compressor contractor and low-pressure control to walk-in freezer, parts replaced. Invoice from Fountain Refrigeration Heating and Air Conditioning provided to facility indicated services completed on 11/22/21 for warm temperature in walk-in freezer. Invoice from Fountain Refrigeration Heating and Air Conditioning provided to facility indicated services completed on 1/13/22; found blown fuse, replaced fuse, and checked apparition, found, and repaired leak, added refrigerant in walk-in freezer. Invoice from Fountain Refrigeration Heating and Air Conditioning provided to facility indicated services completed on 1/21/22; walk-in freezer warm, evaporator all iced up; defrost clock not turning, ordered and repaired clock. Invoice from Fountain Refrigeration Heating and Air Conditioning provided to facility indicated services completed on 4/18/22; walk-in freezer running warm at 10 degrees Fahrenheit, thermostat turned down to -3 degrees Fahrenheit, maintenance to watch operation. M-A indicated after review of invoices; was aware of recommendations for walk-in freezer provided	F 812		

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F 812	Continued From page 43 per Cress Refrigeration on 9/4/21 invoice, M-A confirmed he did not follow-up on implementing recommendations provided for walk-in freezer, wasn't given a guarantee by refrigeration companies that recommendations provided for walk-in freezer would work. During an interview, on 4/28/22 at 2:51 p.m., administrator provided policy for monitoring of cooler/freezer temperature; indicated all dietary staff should be monitoring and recording cooler/freezer temperatures, notifying maintenance of any concerns. Administrator indicated if maintenance identified a concern with cooler/freezer, should repair if able; if unable to repair, contact contract service companies to further evaluate and notify administrator. Administrator verified past issues with walk-in freezer, confirmed M-A should have completed recommendations provided by Cress Refrigeration on 9/4/21 invoice. Administrator indicated she had put in a request for replacing walk-in freezer, awaiting board response. Administrator indicated she was unaware of any unmarked/undated or expired food/beverage found during kitchen tour, would expect all food/beverage items are labeled/dated when opened, discarded within 7 days after opening or per expiration date per policy. Facility policy titled, Food Storage, dated 2010, included date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed, sold, or discarded. Facility policy titled, Date Marking for Food Safety, dated 2017; indicated refrigerated, ready-to-eat, time/temperature control for safety food shall be held at a temperature of 41 degrees	F 812		

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F 812	Continued From page 44 Fahrenheit or less for a maximum of 7 days, the food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded, the discard day or date may not exceed the manufacturer's use-by-date, or four days, whichever is earliest. Facility policy titled, Monitoring of Cooler/Freezer Temperature, dated 2017, included; if temperatures are above 41 degrees Fahrenheit for coolers or 10 degrees Fahrenheit for freezer the supervisor will be notified immediately for corrective action, the unit will be repaired as soon as possible, food will never be stored directly above or in contact with ice, refrigerated food shall be labeled/dated/monitored so that it is used by the use by date, frozen, or discarded, whichever is applicable.	F 812		
F 868 SS=C	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary.	F 868		6/13/22

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F 868	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assurance (QA) committee met on a quarterly basis throughout the past calendar year, to work on improving patient care and fixing any identified areas of concern. This had potential to affect all 24 residents residing in the facility. Findings include: Review of a QAA committee / Attendance Record dated 4/1/21, identified all required members met for the meeting. Review of a QAA committee / Attendance Record dated 7/15/21, identified all required members met for the meeting. Review of a QAA committee / Attendance Record dated 9/16/21, identified all required members met for the meeting. Review of a QAA committee / Attendance Record dated 2/10/21, identified all required members met for the meeting. There was no evidence a QA meeting had been held with the required members to discuss and review identified quality deficiencies or areas in-need of work and improvement about the facility on 12/21. (over 90 days). Interview on 4/28/22, at 2:43 p.m., the administrator and director of nursing (DON) confirmed the facility did not have a quarterly QA committee meeting in 12/21.	F 868	F868 QAA Committee It is the facility's intent to comply with the regulation for the Quality Assurance and Assessment Committee to meet at least quarterly. The corrective action taken for 24 out of 24 residents is to follow through on the quarterly meetings, to follow through on the Plan of Correction to verify deficiencies are not repeated and substantial compliance is identified. The facility identified that all residents had the potential to be harmed due to a lack of the QAA Committee meeting quarterly to identify issues with respect to which quality assessment and assurance activities are necessary. The measures that were put into place was the development of a QAA Committee Meeting quarterly schedule and an audit was implemented during the May 19, 2022, QAA Meeting. During the QAA Meeting held on May 19, 2022, with the Medical Director, Pharmacist, Administrator, Director of Nursing, MDS Coordinator, Social Services/Activity Director, Scheduling Coordinator, Environmental Services Coordinator, and the Food Services Director the tentative deficiencies including QAA compliance were identified and reviewed with the plan of action started. The required members discussed and began developing the plan of correction for the tentative deficiencies announced by the MDH surveyors upon exit on April	

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F 868	Continued From page 46 Review of the facility policy Quality Assurance and Program Improvement, dated 2021, included; 2. The QAA Committee shall be interdisciplinary and shall: a. Consist at a minimum of: i. The Director of Nursing Services; ii. The Medical Director or his/her designee; iii. At least three other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member or other Individual in a leadership role; and iv. The Infection Preventionist. b. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary. c. Develop and implement appropriate plans of action to correct identified quality deficiencies. d. Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. e. The QAA committee must sign to verify approval of all plans of correction written.	F 868	28, 2022, regarding the identified quality deficiencies and areas in need of improvements. At the All-Staff meeting on June 2, 2022, the team members will be educated on the 2567 deficiencies revealed by the MDH survey team and the plan of correction goals plus the expectations moving forward. The review and discussion of the MDH survey results and the Plan of Correction were added to the quarterly QAA agenda. The facility will monitor the audits quarterly times four which will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The QAA will review meeting agendas and meeting minutes to ensure adherence to the Plan of Correction. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 921	F921	6/13/22

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F 921	Continued From page 47 failed to maintain a functional and sanitary living environment which included unclean or not in good repair: floors, ceilings, ice maker machine, walls and doors in resident corridors. This had the potential to affect all 24 residents in the facility. In addition, the facility failed to address a heat register in disrepair for 1 of 1 residents (R24) looked at for environment. Findings include: During an observation on 4/25/22, at 3:14 p.m., observed a damaged cover over the heat register in R24's room. The heat register cover had a dent over approximately a quarter of it and was depressed about halfway down with a jagged metal edge protruding on the inner corner. The back side of R24's headboard was facing the heat register, but approximately two feet from it. During an observation on 4/25/22, at 4:36 p.m., multiple stained ceiling tiles were noted in resident corridors. The stains were gold/light brown in color, most were circular with jagged edges and of varying sizes. The stained tiles were noted in three main areas: 1) three ceiling tiles in the center of the corridor near the east nurses station, 2) approximately 16 ceiling tiles in the center of the corridor near the west nurses station, 3) five ceiling tiles between the east nurses station and janitors closet which was a corridor residents were taken through to get to a tub room. During a dining observation on 4/25/22, at 4:56 p.m., the floor of one of two dining rooms -- the dining room used for residents who needed assistance with eating -- was sheet vinyl, white in color with speckles of gray and tan. The entire	F 921	Safe/Functional/Sanitary/Comfortable Environment It is the facility's intent to comply with the regulation to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The corrective action taken for 24 out of 24 residents is to clean or repair floors, ceilings, ice maker machine, walls, and doors in resident corridors. The heat register in Resident 24 rooms was repaired. The facility identified that all residents were potentially at risk for harm when a functional and sanitary living environment is unclean and in need of repair. The measures that were put into place were to educate all staff on their responsibility for reporting facility equipment/maintenance/environmental needs as per policy & procedure. The Maintenance Services Coordinator ordered ceiling tiles on 5/25/2022 for the replacement of the stained tiles found to be deficient in the assisted dining room, and down the main resident corridors. The damaged heat register covers found to be deficient were replaced on April 27, 2022. The toilet seat in the east bathroom was replaced on 5/9/2022. The Maintenance Services Coordinator ordered Anti-slip Paint Additive, and Epoxy Activator/finish on May 25, 2022, to seal/paint the floor in the west tub room. The Maintenance Service Coordinator obtained the product from our Hillyard vendor to remove rust from the west whirlpool.	

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F 921	Continued From page 48 floor appeared unclean due to many scratches, scuffs and black marks, and was sticky in the higher traffic area near the entrance to the room and around the first two tables. During an interview on 4/27/22, at 9:36 a.m., nursing assistant (NA)-A was aware the cover over the heat register heater in R24's room was damaged and stated it has been that way for a few months. NA-A was unaware if anyone had reported it to maintenance. During an interview on 4/27/22, at 10:59 a.m., maintenance director (MD)-A was aware the cover over the heat register in R24's room was damaged and stated it was due to staff lowering the bed on top of it. MD-A stated he would replace it. During an observation and interview on 4/27/22, at 12:46 p.m., while standing in the dining room used for residents who needed assistance with eating, housekeeper (H)-A, was asked about the flooring. H-A stated they [housekeepers] scrub the floor with a mop, adding she knew it needed a deep scrubbing, which was something maintenance would do, "but there is only one of them." H-A stated the floor had been in this condition for a while. During an observation and interview on 4/27/22, at 12:54 p.m., an ice maker machine was visualized to have a bent metal wiring tray covering lid. Tray catching excess ice/melted water; observed to have white limescale covering, water in tray, pieces of brown discolored debris floating in water/on tray. Dietary aide (DA)-A indicated kitchen staff wipe down ice maker machine at least once daily. DA-A stated deep	F 921	The Maintenance Service Coordinator received a bid on 5/26/2022 for the floor repair strip and wax from Murry Carpet Care the local floor vendor, which is scheduled to be completed. The Maintenance Service Coordinator will repair the main resident dining room wooden table legs by refinishing them to remove the scratched circumferential patterns. The Maintenance Services Coordinator will paint the scraped away paint on resident doors in rooms 25 and 29, the service entrance door, the wall outside the entrance to the dining room, the east activity room water cooler, and the west nurse's station deficiencies. The Maintenance Services Coordinator and Food Services Director are facilitating the full cleaning of the ice machine. It was last cleaned on February 10, 2022, so the cleaning schedule will be increased beyond the manufacturer's recommendations to ensure compliance. Education was provided to the Maintenance Services Coordinator on the need to follow through with identified issues and maintain a safe, functional, sanitary, and comfortable environment Weekly environmental audits will be incorporated by SSD and/or designee to ensure the residents have a safe and sanity environment moving forward. The facility will monitor its performance by conducting weekly audits for four weeks and then monthly audits for a safe, functional, sanity, and comfortable environment for three months or until compliance is achieved. The audit will be	

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F 921	Continued From page 49 cleaning and repairs of ice machine was completed by maintenance. During an observation and interview on 4/27/22, at 12:54 p.m., MD-A and registered nurse (RN)-A, while standing in the corridor by the east nurses station, were asked about the stained ceiling tiles throughout the east and west corridors. MD-A stated the stains were from water from the leaky, flat roof, adding he had a company there three times to repair it, the last time being last fall. MD-A stated the company always said they fixed it, but it continued to leak. MD-A stated the last time the stained ceiling tiles had been replaced was last fall as he was waiting to see if the leaking would continue. MD-A stated stained tiles could eventually turn black with mold and acknowledged this could be an infection control concern for residents, and did not provide a homelike environment for residents. RN-A asked MD-A if he could replace the tiles right away. When MD-A was asked how he would know if the leaking had stopped if the tiles were already stained, MD-A stated there would be new leaking, and walked to an area between the east nurses station and janitors closet and pointed to the stained ceiling tiles, and stated those tiles were stained from new leaking. During an interview, on 4/27/22 at 1:03 p.m., maintenance (M)-A indicated ice maker machine used to be managed and cleaned by previous DD, as previous DD requested ice maker machine, once arrived previous DD informed staff she would be responsible for management of. M-A indicated since new DD started at facility, he was unaware of who's responsible for management of ice maker machine. M-A stated he had been trying to help DD out, offered to	F 921	reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	

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F 921	Continued From page 50	F 921		

provide deep cleaning and repairs when needed of ice maker machine. M-A indicated deep cleaning of ice maker machine needed to be completed every 6 months per manufacturer's instructions; was cleaned last at end of February '22, forgot to document that.

During an interview, on 4/27/22 at 1:23 p.m., administrator indicated cleaning and repair of ice maker machine was maintenance's responsibility. Administrator was unaware of previous DD managing ice maker machine; indicated need for further investigation to which department, dietary or maintenance, was managing at time.

During an observation and interview on 4/27/22, at 1:31 p.m. with the administrator, looked at stained ceiling tiles in the corridor and the floor in the assisted dining room. The administrator was aware of both and acknowledged it did not provide a home-like environment for residents and could be an infection control concern if mold developed. The administrator stated she had talked to MD-A last month about the floor and getting help from maintenance in a sister facility. While talking, MD-A joined the conversation. When the administrator asked MD-A about the floor in the assisted dining room, he stated he was aware of the condition of the floor, and wanted to try one more thing to scrub it before enlisting help from sister facility.

During an infection control observation on 4/28/22, at 7:48 a.m., two of two tub rooms were observed. The west tub room had flooring with a mosaic tile pattern in blue colors. There were a significant number of tiles missing on both sides of the tub and a large area at the end of the tub, approximately 3 X 4 feet, where a resident would

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F 921	Continued From page 51 enter and exit the tub with bare feet. There was a rusty grate over a built in space heater attached to wall. The far end of the whirlpool tub was rusty. In the east tub room, the finish was wearing off the surface of the toilet seat where a resident would sit. The top of the heat register was rusty. In addition, paint was scraped off the heat register near the toilet. During an observation and interview on 4/28/22, at 8:34 a.m., with MD-A and RN-A, toured both east and west tub rooms. In the east tub room, MD-A and RN-A were asked about the toilet seat. RN-A acknowledged the toilet seat couldn't be sanitized adequately due to the finish coming off. In the west tub room, both were asked about floor tile missing. MD-A stated he had been working on it; planned to paint the floor in order to seal it, just had not gotten to it yet. MD-A admitted the tiles had been missing for a long time. Since the surface of the floor is down to bare cement, RN-A acknowledged it could pose an infection control issue as it could not be cleaned adequately, and the rough surface had potential to scratch residents feet. When asked about the door and door jams with missing paint, RN-A stated in the past someone came in and touched up surfaces with paint, but it hadn't been done for awhile and as a result, painting projects were building up. During an observation on 4/28/22, at 11:20 a.m., noted paint scraped away on resident doors for rooms 25 and 29, a service entrance door, a wall outside the entrance to the dining room where residents who need assistance dine, and the east activity room door. Further, paint was scraped off the front of the water cooler near the west nurses station and paint was coming off the outer facade of west nurses station desk. These were areas of	F 921		

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F 921	Continued From page 52 the corridors where residents passed on a daily basis. In addition, in the main resident dining room, wooden table legs on all seven tables were scratched, scuffed, or worn off in circumferential patterns. The table legs were a diameter of appropriately 4 x 4 inches. During an interview on 4/28/22, at 11:48 a.m., the environment findings were reviewed with the administrator who had observed some of the findings herself, or had been informed of most by facility staff. When asked how the environment was allowed to reach these conditions, the administrator, who had been at the facility for less than a year, stated that once she took over in her role, she had identified some of the concerns and was working with MD-A to take necessary action. The administrator acknowledged that the findings presented potential infection control issues for residents and did not provide residents with a home-like environment. During an interview, on 4/28/22 at 2:51 p.m., administrator indicated dietary staff are responsible for daily cleaning of ice maker machine, maintenance responsible for deep cleaning/repair, if ice maker machine observed to be dirty or in need of repair; administrator confirmed dietary staff should be cleaning or notifying maintenance for deep clean and any repairs needed. Facility policy titled Safe and Homelike Environment, dated 2022, indicated the facility would provide a safe, clean, comfortable and homelike environment; ensuring residents can receive care and services safely. Facility policy titled Preventative Maintenance	F 921		

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	245436	A. BUILDING _____ B. WING _____	04/28/2022

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F 921	Continued From page 53 Program, dated 2022, indicated the maintenace director was responsible for developing and maintaining a schedule of maintenance services to ensure buildings and equipment are maintained in a safe and operable manner. The maintenace director would assess all aspects of the physical plant to determine if preventative maintenance is required and decide what tasks need to be completed and how often. Facility policy titled, Heartland Senior Living Maintenance Policies & Procedures- Ice Machine Cleaning, undated; indicated maintenance shall perform a regularly scheduled cleaning of the ice machine, depending on the unit on-site there may be a self-cleaning option on a monthly basis that can be done following manufacturer's instructions. Procedures consisted of; maintenance will program the cleaning option on the digital keypad on the front of the unit, auto-clean process should be on a monthly schedule, annual maintenance will disassemble the machine and fully clean and disinfect the unit, following instructions on the front panel for the machine and the manufacturer's recommendations.	F 921		

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	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2022**

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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 04/28/2022. At the time of this survey, PARKVIEW CARE CENTER-WELLS 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 | 05/27/2022

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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	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2022**

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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. PARKVIEW CARE CENTER-WELLS is a one-story building with a partial basement. The original building was built in 1961 and was determined to be of Type II (222) construction. In 1967 an addition was built with a partial basement and was determined to be of Type II (111) construction. In 1999 an addition was constructed and determined to be of Type III (000) construction.	K 000		

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	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2022**

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K 000	Continued From page 2 Because the original building and the additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building - Type II (000). 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 30 beds and had a census of 24 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced 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:	K 271	K271 Discharge from Exits The corrective action taken for all residents was to implement a maintenance prevention and identification program/process that identifies the facility's failure to inspect and properly maintain exit discharges in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7 and 7.1.6.2.	6/13/22

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K 271	Continued From page 3 On 04/28/2022, between 9:30 AM to 1:30 PM, it was revealed by observation that the egress to grade outside of the West corridor exit door had a vertical displacement greater than one-half inch presenting a fall and trip hazard. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 271	The facility identified that all residents have the potential to be impacted by not proactively identifying the facility□s failure to inspect and properly maintain exit discharges. The measures that were put into place were the Environmental Services Coordinator and/or designees will visually observe exits for wear, tear, and generally unsafe conditions that present fall or trip hazards. A bid is being obtained from the local cement contractor who specializes in smaller repair/replacement projects. Visual audits and inspections of the campus concrete and exits will be initiated into the prevention and maintenance program to assure this deficient practice does not reoccur. The facility will monitor/observe and then audit/document monthly the exit conditions at the facility. Any results found not to be in compliance will be brought to the Director of Nursing, and Administrator immediately. The governing Board of Directors and management team will be informed of these issues pertaining to the severity of the exits concrete separation and settling from the building regarding the cost of repair and/or replacement involved. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	

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K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide protection for cooking appliances per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5 and 19.3.2.5.3(9). This deficient finding could have a patterned impact on the residents within the facility. Findings Include:	K 324	K324 Cooking Facilities The corrective action taken for all residents was to implement a maintenance prevention and identification program/process that identifies the facility's failure to inspect and properly implement an inspection and maintenance program that identifies proper smoke barrier protection in accordance with	6/13/22

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K 324	Continued From page 5 On 04/28/2022, between 9:30 AM to 1:30 PM, it was revealed by observation that in the Physical Therapy Room that the residential stove did not have a lock-out device in the proximity of the unit. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5 and 19.3.2.5.3(9). The facility identified that all residents were at risk for harm when a residential stove used in the Therapy Room did not have a lock-out device installed. The measures that were put into place were the vendor Electrical Services was on-site 5/25/2022 to install the lock-out device on the residential stove in the Therapy Room. Any further cooking appliances installed shall be installed with a lock-out device by a qualified professional. The facility will monitor its performance by conducting monthly audits regarding required electrical lockouts within code compliance for two months or until compliance is achieved. Thereafter, the Environmental Services Coordinator will maintain an ongoing checklist to assure that the documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		6/13/22

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K 353	Continued From page 6 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 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, 9.7.7, 9.7.8 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed during documentation review and by observation that there is a discrepancy as to when that the last 5-year inspection of the sprinkler system was completed. Date observed on the sprinkler system gage was 03/09/2012. Annual inspection documentation of the sprinkler system dated 04/21/2022 indicated that 5 year	K 353	K353 Sprinkler System-Maintenance and Testing The corrective action taken for all residents was to implement a maintenance prevention and identification program/process that identifies the facility's failure to inspect and properly maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, 9.7.8 and NFPA (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.2.2. The facility identified that all residents have the potential to be impacted by a sprinkler system that is not inspected every five years and interference from cabling being attached to the sprinkler system piping.	

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K 353	Continued From page 7 inspection had not been done - but did not provide any additional information. 2. On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed by observation that in the Kitchen and Dishwashing Area that sprinkler heads exhibited signs of oxidation 3. On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed by observation that in the Basement that cabling was attached to the sprinkler system piping 4. On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed by observation that resident RM 34 that cabling was attached to the sprinkler system piping An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	The measures put into place was the Environmental Services Coordinator contacted the sprinkler system vendor Olympic Fire Protection Corp on 5/25/2022 and is waiting to receive a confirmation date from the technician for replacing the oxidized sprinkler heads in the Kitchen and Dishwashing Area. On 4/26/2022 the cabling that was attached to the sprinkler system piping in the Basement and RM 34 were removed by the Environmental Services Coordinator. Visual audits and inspections of the sprinkler□s piping/sprinkler heads will be initiated into the prevention and maintenance program to assure this deficient practice does not reoccur. The facility will monitor its performance by conducting monthly audits regarding sprinkler system inspections are within code compliance for two months or until compliance is achieved. Thereafter, the Environmental Services Coordinator will maintain an ongoing checklist to assure that the documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101	K 355		6/13/22

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K 355	Continued From page 8 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to document portable fire extonguisher inspections per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed during documentation review that no vendor inspection records were presented to confirm the annual inspection and if any extinguishers required corrective action An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 355	K355 Portable Fire Extinguishers The corrective action taken for all residents was to implement a maintenance prevention and identification program/process that identifies the facility's failure to inspect and properly maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.4. The facility identified that all residents have the potential to be impacted by the failure to have the fire extinguishers inspected, confirming the annual inspections are completed to ensure compliance and documentation that acknowledges the corrective action required. The measures that were put into place was to have the Environmental Services Coordinator and/or designee contact the fire extinguisher vendor Fairmont Fire & Safety on 5/25/2022 to schedule the annual inspection and replace any current deficient fire extinguishers while on-site. The facility will monitor its performance by conducting monthly audits regarding fire extinguisher inspections is within code compliance for two months or until	

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K 355	Continued From page 9	K 355	compliance is achieved. Thereafter, the Environmental Services Coordinator will maintain an ongoing checklist to assure that the documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
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 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 maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4.1. This deficient finding	K 374	K374 Subdivision of Building Spaces-Smoke Barrier The corrective action taken for all residents was to implement an inspection	6/13/22

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K 374	Continued From page 10 could have a widespread impact on the residents within the facility. Findings include: On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed during the walk through of the facility that upon testing of the E Wing smoke barrier doors they did not self-close and seal properly to resist the passage of smoke. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 374	and maintenance program that identifies proper smoke barrier protection in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4.1. The facility identified that all residents have the potential to be harmfully impacted by Smoke Barrier door assemblies that do not self-close and seal properly to resist the passage of smoke. The measures that were put into place is the Environmental Services Coordinator adjusted the closure on 5/23/2022 to ensure the seal resists the passage of smoke. The facility will monitor its performance by conducting monthly audits regarding the self-closure and seal is within code compliance for two months or until compliance is achieved. Thereafter, the Environmental Services Coordinator will maintain an ongoing checklist to assure that the documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping	K 511		6/13/22

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	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2022**

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K 511	Continued From page 11 complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper security of electrical panels in a resident accessible corridor in accordance with NFPA 99, (2012 edition), NFPA 70 (2011 edition), National Electrical Code, section 110.26(F) Health Care Facilities Code, section 6.3.2.2.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed by observation that the electrical panel in a resident accessible corridor, the small Dining Room, was found unsecured An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	K511 Utilities-Gas and Electric The corrective action taken for all residents was to implement an inspection and maintenance program that identifies proper smoke barrier protection in accordance with NFPA 99 (2012 edition), NFPA 70 (2011 edition), National Electrical Code, section 110.26(F) Health Care Facilities Code, section 6.3.2.2.1.3. The facility identified that all residents have the potential to be harmfully impacted by an unsecured electrical panel in the Dining Room accessible to residents. The measures that were put into place is the Environmental Services Director installed a lock and hasp on the electrical panel on 5/11/2022 securing the panel that was accessible to the resident. The facility will monitor its performance by conducting monthly audits to ensure unsecured electrical panels are within code compliance for two months or until compliance is achieved. Thereafter, the Environmental Services Coordinator will maintain an ongoing checklist to assure that the documentation is kept current and	

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K 511	Continued From page 12	K 511	accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and staff interview, it was revealed that the facility is using the corridors as an air plenum which is not in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.5.2, 8.5, 8.5.5.2, 8.5.5.4.2, NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 4.3.12.1.1. This deficient condition could have a widespread impact on the residents within the facility.	K 521	K521 HVAC The corrective action taken for all residents was to implement an inspection and maintenance program that identifies proper smoke barrier protection in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19. 5. 2, 8.5, 8.5.5.2, 8.5.5.4.2, NFPA 105 92012 edition) The facility identified that all residents were at risk for harm due to not confirming the smoke damper inspection and testing results.	6/13/22

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K 521	Continued From page 13 Findings include: 1. On 04/28/2022, between 9:30 AM to 1:30 PM, it was revealed by a review of available documentation that the last confirmed smoke damper inspection was completed on 11/2017. The facility had a newer billing statement dated 08/2021 but no confirming documentation associated with the smoke damper inspection and testing. 2. On 04/28/2022 between 9:30 AM to 1:30 PM, observations, documentation review and staff interview revealed the ventilation system in the 1961 and 1967 buildings utilized the egress corridors as a return air plenum for the building HVAC system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	It was identified that the 1961 and 1967 buildings utilize the egress corridors as a return air plenum for the building's HVAC. The measures that were put into place were the Environmental Services Coordinator contacted the smoke damper inspection vendor Jim and Dudes to schedule an inspection and testing of the damper equipment. Replacement of the return air plenum for the building□s HVAC deficiency- A. Compliance with this provision will cause an unreasonable hardship because: 1. Facility will secure a recent cost for a complying ducted HVAC system and send a copy with the waiver to the Deputy State Fire Marshal. 2. Efforts to obtain an estimate for a ducted system have been unsuccessful. 3. A ducted system would decrease the corridor headroom to less than that required by the LSC. 4. The building's electrical system would need to be upgraded to support a new ducted system. 5. The ducted system would need to penetrate load-bearing walls, decreasing building structural integrity. 6. Installation of a ducted system would require asbestos abatement which would increase the cost. 7. Existing non-complying HVAC systems can be allowed to continue in use. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that is compliant	

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K 521	Continued From page 14	K 521	2. The existing HVAC system ventilation fans do automatically shut down upon activation of the fire alarm system, or detection of smoke in the HVAC system. 3. Resident sleeping rooms do have smoke detectors in lieu of fire sprinklers. 4. The corridors are equipped with a complying smoke detection system. 5. The facility is in compliance with all other fire safety requirements, or 6. The facility has obtained an approved plan of correction for any other fire safety deficiencies that were cited. 7. This annual/continuing waiver has been approved in the past. 8. A waiver will be sent in to the Deputy State Fire Marshal's office with an updated cost estimate. The facility will monitor its performance by conducting monthly audits to ensure smoke dampers inspections are within code compliance for two months or until compliance is achieved. Thereafter, the Environmental Services Coordinator will maintain an ongoing checklist to assure that the documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101	K 712		6/13/22

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K 712	Continued From page 15 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based a review of available documentation the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.2, and 4.7.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed during documentation review that documentation presented for review identified that fire drills were not conducted during 3rd Shift in the 3rd and 4th quarters. An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 712	K712 Fire Drills The corrective action taken for all residents was to implement an inspection and maintenance program that identifies proper smoke barrier protection in accordance with NFPA 101 (2012) edition), Life Safety Code, sections 19.7.1.6, 4.7.2, and 4.7.6. The facility identified that all residents were at risk for harm if the fire drills are not conducted on all shifts in accordance with the regulations. The measures that were put into place is an audit sheet confirming that all required shifts and fire drills per those quarters are being conducted in alignment with the regulation. The fire drills completed will be reviewed and audited by the Environmental Services Coordinator and/or designee monthly until compliance has been achieved The facility will monitor its performance by conducting monthly audits regarding fire drills within code compliance for three	

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K 712	Continued From page 16	K 712	months or until compliance is achieved. Thereafter, the Environmental Services Coordinator will maintain an ongoing checklist to assure that the documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		6/13/22

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K 914	Continued From page 17 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain electrical receptacles in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2 This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed by observation that an electrical outlet in resident RM 04 West was found to be loose in the electrical housing. 2. On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed by observation that an electrical outlet housing located in resident RM 09 West was found to be dislodged in its mounting to the wall. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	K914 Electrical Systems-Maintenance and Testing The corrective action taken for all residents was to implement an inspection and maintenance program that identifies proper smoke barrier protection in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2. The facility identified that all residents were at risk for harm when there are dislodged or loose outlets. The measures that were put into place were is the Environmental Services Coordinator secured the electrical outlet mountings to the wall on 4/29/2022. The facility will monitor its performance by conducting monthly audits regarding unsecured outlets that are within code compliance for two months or until compliance is achieved. Thereafter, the Environmental Services Coordinator will maintain an ongoing checklist to assure that the documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	

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K 920	Continued From page 18	K 920		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation and usage of electrical adaptive devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and UL1363, AND NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition could have an isolated impact on the residents within the facility.	K 920	K920 Electrical Equipment-Power Cords and Extensions The corrective action was taken for all residents to identify the facility□s failure in having a high amperage appliance connected to a power strip. The facility identified that all residents have the potential to be impacted by utilizing extension cords and not removing them immediately upon completion of the	6/13/22

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K 920	Continued From page 19 Findings include: On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed during facility walk through of the facility that at the N Nurses Station a high amperage appliance was connected to a power-strip An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	purpose for which it was installed and meets the conditions of 10.2.4.10.2.3.6 (NFPA 99), 10.2.4 (NFPA99), 400-8 (NFPA 70), 590.3 (D) (NFPA 70), TIA 12-5. The measures that were put into place is the Environmental Services Coordinator and/or designee will continue to conduct auditing of extension cords usage with the facility to ensure compliance regarding temporary usage and immediate removal of extension cords. The vendor Electric Services was on-site on 5/25/2022 to correct this deficient practice. The facility will monitor its performance by conducting monthly audits to ensure extension cords usage is within code compliance for two months or until compliance is achieved. Thereafter, the Environmental Services Coordinator will maintain an ongoing checklist to assure that the documentation is kept current and accurate. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) at QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	
K 923 SS=C	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		6/13/22

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K 923	Continued From page 20 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections	K 923	K923 Gas Equipment-Cylinder and Container Storage The corrective action was taken for all residents to identify the facility□s failure to	

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K 923	Continued From page 21 11.3.2, 11.3.4, 11.6.5. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed by observation in the Basement Med Gas Storage Room that there was mixed storage of oxygen cylinders 2. On 04/28/2022 between 9:30 AM to 1:30 PM, it was revealed by observation that the Basement Med Gas Storage Room was missing signage to identify the location for storage of full cylinders An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 923	maintain medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.34.11.6.5. The facility identified that all residents have the potential to be negatively impacted by having unsecured cylinders, mixed storage areas, and a lack of signage to identify placement and locations for empty/full cylinders. The measures that were put into place are the Environmental Services Coordinator and/or designee segregating the empty cylinders from the full cylinders. Signage was placed on the separated full and empty cylinders. All staff will be educated on the empty and full cylinder placement locations at the All-Staff on June 2, 2022. The facility will monitor its performance by conducting monthly audits regarding oxygen placement and security for two months or until compliance is achieved. Thereafter, the Environmental Services Coordinator and/or designee will maintain an ongoing checklist to ensure the oxygen storage areas are within compliance and documented. The audit will be reviewed and evaluated by the Interdisciplinary Team (IDT) and QAPI and QAA to determine appropriateness and effectiveness. The tentative deficiency was reported to QAA on 5/19/2022 The plan of correction will be reported to the QAA on 8/18/2022. The above corrective action measures will be completed on or before 6/13/2022.	