DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SK2Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00581

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E355**
2.STATE VENDOR OR MEDICAID NO.
(L2) **780743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AFTENRO HOME**
(L4) **510 WEST COLLEGE STREET**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/10/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		54		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Frericks, Unit Supervisor 01/03/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/03/2022 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/12/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2022

CMS Certification Number (CCN): 24E355

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

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 Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective November 4, 2021 the above facility is certified for:

54 Nursing Facility I Beds

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2022

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

RE: CCN: 24E355
Cycle Start Date: September 27, 2021

Dear Administrator:

On October 20, 2021, we notified you a remedy was imposed. On November 10, 2021 the Minnesota Department(s) of Health 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 November 4, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 4, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 20, 2021, 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 September 27, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 4, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SK2Y

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(L4) **510 WEST COLLEGE STREET**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/27/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		54		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE - NE II 12/10/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/31/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/12/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
October 20, 2021

Administrator
Aftenro Home
510 West College Street
Duluth, MN 55811

RE: CCN: 24E355
Cycle Start Date: September 27, 2021

Dear Administrator:

On September 27, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 22, 2021, the situation of immediate jeopardy to potential health and safety cited at F 678 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 4, 2021.

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

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 4, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 4, 2021, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 27, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information,

you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Aftenro Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 27, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 27, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this

letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	C 09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/20/21, through 9/27/21, 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 9/20/21, through 9/27/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F678 when the facility failed to ensure a system to identify a resident's resuscitation status was accurately reflected throughout the medical record and facility documents for 1 of 16 residents reviewed for advanced directives that posed an immediate risk to resident health and safety. The IJ began on 9/21/21, at 5:26 p.m. and was removed on 9/23/21, at 10:05 a.m., when it could be verified by observation, interview and document review the facility had accurately identified all resident's code status, updated the policy and educated staff.	F 000		

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

Electronically Signed | 10/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING _____ B. WING _____	C 09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 In addition, an extended survey was completed on 9/27/21, related to the substandard quality of care findings. The complaint HE355015C (MN68546) was found to be SUBSTANTIATED with related deficiencies at F812. The complaint HE355016C (MN74101) was found to be SUBSTANTIATED. No deficiencies were cited due to the corrective actions taken by the facility prior to the survey.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a resident did not self-administer medications (SAM) as assessed and according to the care plan for 1 of 1 residents (R27) reviewed for SAM. Findings include: R27's Admission Record printed 9/24/21, indicated R27's diagnoses included moderate persistent asthma, pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and heart causing shortness of breath, dizziness, and chest pressure), depression, polymyalgia rheumatica (an inflammatory disorder causing muscle pain and stiffness), obstructive sleep apnea (intermittent airflow	F 554	F554 All residents have the potential to be affected by this practice. It is the policy of Aftenro to assess each resident that requests to self administer their medications. The facility Self-Medication Policy was reviewed. R27's care plan and orders have been reviewed and updated for self administration of medication. After assessing the resident, the IDT has determined that R27 is not safe or appropriate to self administer medications.	11/4/21

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F 554	Continued From page 2 blockage during sleep), and muscle weakness. R27's quarterly Minimum Data Set dated 8/11/21, indicated R27 was cognitively intact and was independent with her activities of daily living (ADL). On 9/20/21, at 1:01 p.m. during an interview with R27, a medication cup was observed on a table in her room. There were seven pills in the cup. A staff member came in but didn't say anything to R27. R27 stated the nurse was probably checking to see if she took her pills. R27 stated she kept her door locked whenever she left her room. R27's Order Summary Report printed on 9/24/21, had orders as follows: -Provide resident with a bottle of in house muscle rub to use on her legs four times a day. May self-administer. -Saline nasal spray two puffs in both nostrils two times a day for dry nares. Resident may self-administer. -Allopurinol (for gout) 300 milligrams (mg) daily, ascorbic acid (supplement) 250 mg twice daily, aspirin (for heart failure) 81 mg daily, cetirizine HCl (for allergies) 10 mg daily, Eliquis (blood thinner) 5 mg twice daily, ferrous sulfate (iron supplement) 325 mg twice daily, Lyrica (for pain) 100 mg three times a day, multivitamin daily, pantoprazole sodium (for acid in stomach) 20 mg daily, potassium (for minerals) 20 milliequivalents (mEq) daily, senna-docusate sodium (for constipation) 8.6-50 mg twice daily, sertraline HCl (for depression) 25 mg daily, spironolactone (for high blood pressure) 50 mg daily, Toresemide (for edema) 40 mg daily, acetaminophen (pain) 650 mg three times a day, and vitamin D3	F 554	The DON has re-educated LPN A on the Atenro self-administration of medication policy All licensed staff and TMAs will be re-educated on the current self-administration policy and facility□s nursing practice. This will be completed by all licensed staff no later November 4th, 2021. The Director of Nursing, ADON, or designee will audit 3 medication administration passes each week x 30 days, 2 medication administration medication passes each week x 30 days, and 1 medication administration medication pass each week x 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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F 554	Continued From page 3	F 554		

(supplement) 1000 units daily. None of the listed medications had self-administration orders.

R27's care plan dated 6/15/17, indicated R27 could self-administer her Albuteral neb treatment three times a day. Resident was to be assessed by nursing to evaluate her proficiency for self-administration.

Assessment(s) for self-administration of medications was requested but not provided.

On 9/24/21, at 12:34 p.m. licensed practical nurse (LPN)-A stated she would leave pills for R27 because she would not take them in front of her, she would allow R27 to take the medications back to her room. LPN-A stated she would keep going back to check to see if R27 took them. LPN-A verified she left medications in R27's room on 9/20/21. She further stated R27 was not care planned for self-administration nor was she assessed for SAM.

On 9/24/21, at 2:25 p.m. the director of nursing (DON) stated "none of the residents are able to self-administer medications." The DON further stated he would not expect to see any medications in a medication cup in a resident room, nor would he expect to see a resident carrying a medication cup down the hallway to their room to take the medications later.

The facility's Administering Medications policy, undated, indicated residents may self-administer their own medications only if the attending physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.

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F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		11/4/21

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F 584	Continued From page 5 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a toilet seat/arm rest attachment was cleanable and in good repair for 1 of 1 residents (R35) reviewed with a toilet seat attachment. Findings include: R35's Admission Record printed 9/24/21, indicated R35's diagnoses included dementia, chronic kidney disease, history of falling, left knee osteoarthritis, and osteoporosis. R35's quarterly Minimum Data Set (MDS) assessment dated 8/28/21, indicated R35 had a severe cognitive deficit, required extensive assistance with toilet use, had an unsteady balance though was able to stabilize without assistance. R35's care plan revised 3/4/21, indicated R35 had an activity of daily living (ADL) self-care performance deficit and required assistance of one staff for toilet use and incontinent care. R35's care plan indicated R25 had a grab bar on the right and left sides of the toilet and a wall grab bar on the right side to assist with safe transfers and to steady self when flushing the toilet. On 9/20/21, at 1:47 p.m. R35's toilet seat/arm rest was observed to have chipped paint on the front metal piece, and had a dark, potentially rusted metal exposed. On 9/24/21, at 2:36 p.m. R35's toilet seat/arm	F 584	F584 R35□s toilet seat was replaced on the date of the finding, 9/20/2021 by the maintenance department. All residents have the potential to be affected by this practice. The Maintenance Director or designee will audit all bathroom and medical equipment to ensure it is safe and functional no later than November 4th, 2021. Nursing and maintenance staff will be educated on the importance of ensuring residents are using safe and functional equipment. This will be completed by all nursing and maintenance staff no later than November 4th, 2021. The Maintenance Director or designee will audit 5 resident rooms per week x 30 days, 3 resident rooms per week x 30 days, and 2 resident rooms per week x 30 days, for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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F 584	Continued From page 6 rest attachment remained chipped with potential surface rust. On 9/24/21, at 2:42 p.m. the director of nursing (DON) verified the chipped surface on the toilet seat/arm rest was not a cleanable surface and could have sharp edges. The DON stated R35's toilet seat/arm rest needed to be replaced. A facility policy and procedure was requested but not provided.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585		11/4/21

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F 585	Continued From page 7	F 585		

contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,

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F 585	Continued From page 8 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a report of missing money was followed up on for 1 of 1 residents (R37) reviewed for missing property. Findings include: R37's Admission Record printed 10/27/21, indicated R37's diagnoses included stage three chronic kidney disease, and depression.	F 585	F585 Aftenro does follow it's grievance policy. A grievance form was completed by Social Services on 9/24/21 for R37□s missing money. An investigation was conducted; however, resident would not allow staff to search through her belongings. Therefor the missing money	

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F 585	Continued From page 9 R37's annual Minimal Data Set (MDS) dated 8/18/21, indicated R37 had intact cognition, no behaviors or rejection of care, and was independent in bed mobility, transfers, toileting, and personal cares. On 9/20/21, at 6:22 p.m. R37 stated she had reported to the administrator, earlier that day at the resident council meeting, that she was missing $78.00 in cash. R37 stated her money was in her check book in her top drawer and when she went to a check, R37 discovered the money was missing. R37 stated she wrote checks monthly and the money was in the checkbook last month. R37 stated she was unsure what the resolution was going to be. On 9/23/21, at 2:35 p.m. the social services designee (SSD)-A stated during the resident council meeting on 9/20/21, R37 report to the administrator R37 was missing money. SSD-A stated the process for missing money would be to talk to the resident, complete a concern form and encourage the resident to keep money in a resident trust account. SSD-A stated she had not talked with R37 about the missing money, and had not completed a concern or grievance form, or initiated an investigation. On 9/24/21, at 2:02 p.m. the administrator stated during resident council meeting on 9/20/21, R37 reported missing about $79.00. The administrator stated R37 reported the money went missing within the past month but R37 was unable to give a specific date or time frame. The administrator stated he informed SSD-A about R37's missing money and had not had the time to follow up with R37. The administrator further	F 585	was not located. However, a resolution was determined by mounting a lock box in her room so that R37's money could be secured. The resident will have a key, and a second key will be kept in the business office safe. All residents have the potential to be affected by this practice. All Aftenro staff will be educated on the facility□s grievance policy. This will be completed by all staff no later than November 4th, 2021. All grievances will be reviewed by the Aftenro IDT at morning-stand-up. An audit tool will be utilized to ensure that all grievance components are completed to include proper notifications including police report (if needed), a through investigation with findings, and a resolution. The audit tool will be completed and will be reported at the monthly QAPI meetings for the 90-day period.	

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F 585	Continued From page 10 stated he did not complete a concern or grievance form or initiate an investigation. The administrator stated R37 could not give dates when the money went missing, so it would be difficult to interview staff and investigate the missing money. The administrator stated the importance of following the grievance policy and initiate an investigation timely would be to prevent the event from happening to others. The facility policy Grievance (Problem/Concern) Policy and Procedure dated 9/20/19, directed to take immediate action to prevent further potential violations of any resident's right while the alleged violation is being investigated.	F 585		
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the abuse policy provided direction for reporting all potential resident-to-resident abuse incidents; report immediately, but no later than 2 hours, to the administrator and state agency ; and to report	F 607	F607 The abuse policy was updated during the week of the survey to include reporting immediately, but no later than 2 hours, to the administrator, and state agency; and	11/4/21

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F 607	Continued From page 11 facility investigation to the state agency within five working days. In addition, the facility policy lacked direction to ensure staff received annual abuse/VA training. This had the potential to affect all 48 residents residing in the facility. Findings include: A review of the undated facility Abuse Policy and Procedure revealed: - resident-to-resident abuse was an exemption from reporting requirements and did not have to be reported to the state agency if it did not cause serious injury. The facility policy lacked: -direction to report potential abuse allegations to the state agency immediately, but no later than two hours. -direction for facility investigations of potential abuse allegations to be reported to the state agency within five working days. -direction for staff to receive annual abuse prevention and vulnerable adult training. A review of the staff education completion of Abuse/VA training, revealed nursing assistant (NA)-D with a start date of 3/26/20, and licensed practical nurse (LPN)-C with a start dated of 2/20/19, had not completed annual abuse/VA training. On 9/23/21, at 10:16 a.m. the administrator verified the facility policy for abuse lacked direction to report resident-to-resident abuse allegations immediately to the administrator and state agency, and did not need to involve serious injury to be reported. The administrator further	F 607	report investigation to stage agency within 5 working days. The policy was also updated to include specifics on staff training which is to be completed annually. All residents have the potential to be affected by this practice. All staff will be educated on the facility□s Vulnerable adult policy no later than 11/4/2021. The DON, ADON, or designee will randomly audit 8 staff members per week on the facility□s Vulnerable adult policy x 30 days, 5 staff members per week x 30 days, and 3 staff members per week x 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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F 607	Continued From page 12 verified facility investigations should be completed and reported to the state agency within 5 working days, and staff should receive abuse/VA training at orientation and annually.	F 607		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the	F 655		11/4/21

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F 655	Continued From page 13 resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written copy of the baseline care plan was provided to the resident and/or resident representative for 1 of 1 residents (R21) reviewed for baseline care plans. Findings include: R21's Admission Record printed 9/24/21, indicated R21's diagnoses included symptoms and signs involving cognitive functions following cerebral infarction (stroke), metabolic encephalopathy (alteration in brain chemistry that affects brain function), atrial fibrillation (heart irregularity), and chronic obstructive pulmonary disease (COPD). R21's comprehensive admission Minimum Data Set (MDS) assessment dated 8/10/21, indicated R21 was admitted to the facility on 7/28/21, had a moderate cognitive impairment, usually understood others and was usually understood by others. R21's MDS indicated R21 required extensive assistance with locomotion off the unit, transfers, dressing, toilet use and hygiene, was at risk for pressure ulcers, and had one fall since	F 655	F655 The baseline care plan process has been reviewed. Resident's/responsible party will receive a written copy of the baseline care plan within 48 hours of the resident's admission. R21□s POA was given a copy of resident□s baseline care plan. All new admissions have the potential to be affected by his practice. The DON or designee will provide a baseline care plan within 48 hours of admission. A signed copy acknowledging receipt of the baseline care plan will be scanned and saved under the miscellaneous documents of the resident medical record. All licensed staff will be educated on providing the care plan within 48hrs. The DON or designee will audit all new admissions for a period of 90 days to	

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F 655	Continued From page 14 admission. R21's comprehensive care plan indicated it was initiated on 7/29/21, and addressed fall risk with interventions, identified cognitive function and deficits, activities of daily living (ADL) function and needs, toileting and incontinent needs, mood concerns, and nutritional and dental concerns within the first 48 hours. R21's care guide printed 9/24/21, indicated R21 was admitted on 7/28/21, and directed nursing assistant provision of daily care, but lacked a date it was initiated, resident goals, or indication that it was a baseline care plan. A review of R21's medical record lacked evidence of a baseline care plan. On 9/24/21, at 1:02 p.m. the director of nursing (DON) verified a written copy of the baseline care plan has not been provided to residents or resident representatives. The DON stated R21 had a care conference and the care plan was reviewed. The facility policy and procedure for Care Planning-Interdisciplinary Team dated 8/21, lacked direction for development within 48 hours of admission, and provision of a written copy of the baseline care plan.	F 655	ensure that a baseline care plan has been provided within 48 hours of admission.	
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to	F 678		11/4/21

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F 678	Continued From page 15 related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure documentation of each resident's advance directive/code status was consistent throughout their records to ensure the code status reflected resident current resuscitation preferences and physician orders. The facility's failure resulted in an immediate jeopardy, risk of serious harm, injury, impairment, or death for 1 of 16 residents (R27) reviewed for advance directives. The immediate jeopardy began on 5/18/20, when R27 changed her preference from requesting cardiopulmonary resuscitation (CPR) to do not attempt resuscitation (DNR). R27's electronic record and hard copy record listed discrepancies in R27's most current code status and the facility lacked a system of where staff should look for current code status. The administrator and the director of nursing (DON) were notified of the immediate jeopardy on 9/21/21, at 5:26 p.m. The immediate jeopardy was removed on 9/22/21, but noncompliance remained at the lower scope and severity of a D, isolated harm that is not immediate jeopardy. Findings include: R27's Admission Record printed 9/24/21, indicated R27's diagnoses included moderate persistent asthma, pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and heart causing shortness of breath, dizziness, and chest pressure), depression, polymyalgia rheumatica (an inflammatory	F 678	F678 The facility has updated R27□s Advanced Directive/POLST/Code Status form in the resident□s medical chart. All residents have the potential to be affected by this practice. To ensure that documentation of each residents' advance directive/code status is consistent throughout their medical record, the facility has established that the advance directives/POLST/code status will be kept in one location, the residents chart located at the 2nd floor nurse□s station. As removal remedies, the facility reviewed each resident chart for code status and educated all nursing staff at their next scheduled shift on where the Advance Directive/POLST/Code Status is maintained. It is kept in the resident□s paper record. The training included a video that was posted at the time clock and education also occurred on the floor. Each nursing employee has signed an acknowledgment form and will be kept in the POC binder. The Director of Nursing, ADON, or designee will audit 10 medical records each week x 30 days, 5 medical records each week x 30 days, and 2 medical	

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F 678	Continued From page 16 disorder causing muscle pain and stiffness), obstructive sleep apnea (intermittent airflow blockage during sleep), and muscle weakness. R27's quarterly Minimum Data Set dated 8/11/21, indicated R27 was cognitively intact and was independent with her activities of daily living (ADL). On 9/21/21, at 3:27 p.m. R27 stated she would only want CPR if they could revive her with "one shock", she further stated she did not wish to be on any life support. On 9/21/21, at 8:23 a.m., R27's physician orders indicated R27 had a physician order for DNR dated 5/18/20. This order in R27's electronic medical record (EMR) created an "alert" in her EMR banner that indicated DNR. R27's hard chart had a POLST dated 6/19/17, signed by R27 indicating she wanted CPR. The POLST was signed by R27's provider on 7/7/17. In addition, there was a label on the outside of R27's hard chart that indicated "full code." R27's hard chart did not include any further POLST forms. On 9/21/21, at 9:30 a.m. the blue POLST binder on top of the crash cart on the second floor had a copy of R27's POLST dated 5/18/20, which indicated DNR. On 9/21/21, at 9:52 a.m. the assistant director of nursing (ADON) stated staff would look for resident's code status in the EMR banner or in the blue POLST binder on top of the crash cart. The code book contained resident's POLST. The ADON stated the POLST could also be found in the hard chart under the advance directive tab and in the EMR scanned into miscellaneous	F 678	records x 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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F 678	Continued From page 17	F 678		

documents.

On 9/21/21, at 10:00 a.m. registered nurse (RN)-B stated she would look for a resident's code status in the EMR (the code status was in the banner and in the orders) or if it was closer (there are two floors with residents on each floor second and third) in the blue POLST binder on top of the crash cart (on the second floor), or check with the charge nurse. RN-B stated she did not think the POLST was in the hard chart.

On 9/21/21, at 10:02 a.m. the director of nursing (DON) stated he would expect staff to look in the resident's hard chart for resident current code status. The DON further stated he trained new staff (nurses and nursing assistants) in CPR and he instructed them to look in the resident's hard chart for the signed POLST to determine code status. In the hard chart the POLST was located under an advance directive tab. The DON stated a copy of the POLST was also located in the EMR but he trained staff to look in the hard chart.

On 9/21/21, at 10:46 a.m. the DON reviewed the facility's CPR Initiation policy and stated he was not in agreement with the policy. He stated again staff should be going to the hard chart to verify a resident's code status.

On 9/21/21, at 12:10 p.m. nursing assistant (NA)-B stated she would check for a resident's code status at the desk in the "white book", she further stated she could also look in the hard chart. NA-B was not certain what color the code book was or where it was kept.

On 9/21/21, at 12:13 p.m. licensed practical nurse (LPN)-A stated she would look for a resident's

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code status in the EMR if she was in the EMR. LPN-A further stated she would check the hard chart to verify that it was correct because in other places she had worked it wasn't always correct in the EMR.

On 9/21/21, at 12:41 p.m. the DON verified R27's code status in the hard chart under the advance directive tab was listed as full code dated 6/19/17. He further verified R27's code status in the EMR was listed as DNR dated 5/18/20. The DON verified the hard chart had an "old" POLST and was not current. The DON stated, "this is why it should only be in one place."

On 9/21/21, at 12:57 p.m. LPN-B stated she would check the EMR or the blue binder that was kept on top of the crash cart on the second floor for a resident's code status.

On 9/21/21, at 1:00 p.m. registered nurse (RN)-A stated she would look in either the hard chart or the EMR for a resident's code status.

On 9/21/21, at 1:03 p.m. RN-C stated she would look in the EMR for a resident's code status (code status was listed in the EMR banner and in the orders). She further stated if there was a computer failure she would look in the resident's hard chart (the POLST was located under an advance directive tab).

On 9/21/21, at 4:07 p.m. the ADON stated the process for changes in POLST's would be to have the resident and the provider sign the POLST, the health unit coordinator (HUC) would put the order in and that would populate the banner in the EMR. The POLST would then get scanned into the miscellaneous tab in the EMR, a

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copy would go into the blue binder on top of the crash cart located on the second floor. The ADON stated the process stopped there. She was not aware of any process to update the hard chart with the current POLST.

The facility policy titled CPR Initiation dated 8/24/18, located in the blue POLST binder on top of the crash cart, directed staff on the procedure for CPR Initiation as follows:

--Residents that do not have an active DNR order or other advanced care directive specifically declining CPR will be identified by the code status "CPR" on the resident profile in Point Click Care (PCC) directing they are to receive life-saving efforts per their wishes. Residents who do have an active DNR order will be identified by the code status "DNR" on the resident profile in Point Click Care. The electronic medical record (EMR) will also have the active orders as either "CPR" or "DNR" on PCC terminals on the medicine carts, and the mobile computer work stations, making it efficient for staff to identify the resident's most current wishes very quickly. In the unlikely event that the electronic system is down, all POLST and Advance Directive paper copies can be found in the blue binder labeled "POLST/Advance Directives" on the facility crash cart on the second floor. The policy did not address the POLST being located in the resident's hard chart.

The immediate jeopardy that began on 9/21/21, was removed on 9/22/21, at 12:46 p.m. when the facility took the following actions and staff were interviewed to verify as implemented:
-The facility removed all resident advance directives and related physician orders from the EMR, the EMR miscellaneous tab, the banner,

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F 678	Continued From page 20 and the blue binder on the crash cart. The removal of advance directives from all of the locations was verified on 9/22/21, from 7:47 a.m. to 12:45 p.m.. -All resident charts were reviewed on 9/22/21, to ensure the most recent POLST/advance directive were in the resident's hard chart. -All nursing employees (RN, LPN's, and NA's) were educated on the changes. Interviews were completed on 9/22/21, from 7:47 a.m. until 12:45 p.m. to verify education of staff was complete. -The CPR Initiation policy was updated and reviewed on 9/22/21, from 7:47 a.m. to 12:45 p.m. with the following changes: * Residents that do not have an active DNR order or other advanced care directive specifically declining CPR will be identified by the code status "CPR" on their POLST. *All POLST and Advance Directive paper copies can be found in each resident's hard charts at the second floor nursing station. *Reference to blue binder code status and EMR were removed.	F 678		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure weights were consistently	F 684	F684	11/4/21

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F 684	Continued From page 21 completed and followed up on as ordered and/or care planned, for 1 of 1 residents (R33) reviewed for dialysis and the facility failed to ensure high blood sugars outside of parameters were addressed as ordered by the physician and the physician was notified for 1 of 5 residents (R10), reviewed for unnecessary medications. Findings include: R33's Admission Record printed 9/24/21, indicated R33's diagnoses included end stage renal disease, type 1 Diabetes Mellitus (pancreas produced little to no insulin) with hypoglycemia (low blood sugars), dependence on renal dialysis, edema, and hypertension (high blood pressure). R33's quarterly Minimum Data Set (MDS) assessment dated 8/28/21, indicated R33 was cognitively intact, had no significant weight change over the previous month and six months, and received dialysis. R33's Order Summary Report printed 9/24/21, indicated R33's physician orders included directives dated 3/8/21, to obtain a daily weight and make sure the weight was entered in the electronic medical record (EMR) in the morning. In addition, R33's physician orders included a directive dated 10/31/19, to enter before and after weights from dialysis in the vitals signs record every Monday, Wednesday, and Friday. R33's care plan initiated 11/7/19, identified R33's risk of fluid volume overload related to kidney failure with an estimated dry weight of 157.3 pounds. R33's care plan directed staff to weigh R33 at the same time of day and record her weight three times weekly. The resident was to	F 684	R33 is weighed at dialysis pre and post on M-W-F. The facility also weighs R33 pre and post dialysis on M-W-F. The facility weighs the resident daily on all other days. The facility has changed the order for the weights to include specific parameters on when the MD should be called for a significant weight gain/loss; + or □ 3 pounds. The nurse will document the communication between the staff and the primary healthcare provider in the progress notes. R10□s orders for blood sugars were changed so that nurse□s must document Q shift if a PRN Blood sugar and PRN insulin were administered, regardless if it was needed. If a PRN accu-check and insulin are given, the licensed nurse will also document in the progress notes of the results. All residents have the potential to be affected by this practice. All residents who are on daily weights will have specific parameters listed in the order to specify when a MD should be called. Documentation of the communication will be recorded in the resident□s progress notes. PRN accu-checks that are over MD parameters will document in the progress notes specifying the actions taken to address the issue; i.e., MD notification/communication/telephone orders. All licensed staff will be educated on daily	

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F 684	Continued From page 22 be weighed before and after dialysis every Monday, Wednesday, and Friday; the dialysis communication form was to be filled out prior to leaving the facility on dialysis days and weights and problems during dialysis were to be put in R33's chart and reviewed by the rounding physician. In addition, R33's care plan directed nursing staff to monitor, document and report any signs and symptoms of fluid overload, including sudden weight gain. Nursing staff were to monitor, record and report signs and symptoms of hyperglycemia (high blood sugars), including weight loss. R33's Care Guide used by nursing assistants (NA's) directed R33 to be weighed at the same time of day and record three times a week, and weighted before and after dialysis every Monday, Wednesday, and Friday; the dialysis communication form was to filled out prior to leaving the facility on dialysis days. Weights and problems at dialysis were to be reviewed and filed in the chart for the rounding physician to review. R33's weights in the vital sign records in R33's EMR and treatment administration record indicated R33's weights from 9/1/21, through 9/21/21, revealed R33's usual weight had been recorded as being between 156.8 and 164 pounds. In addition, R33's weight record, indicated: -On Tuesday, 9/14/21, R33's weight was up to 167 pounds -On Sunday 9/19/21, R33's weight was up to 176.0 pounds, and was re-checked twice more at 176.0 -On Monday, 9/20/21, R33's weight was 161.8	F 684	weight notifications and blood glucose levels that are not within established parameters. The Director of Nursing, ADON, or designee will audit 5 diabetic and 5 daily weight residents, weekly x 30 days, 3 diabetic and 3 daily weight residents weekly, x 30 days, and 2 diabetic and 2 daily weight residents weekly x 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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R33's progress notes lacked documentation of follow-up on R33's significant weight gain of 9 pounds in a day, assessment for acute change in condition, or notification of the physician.

On 9/24/21, at 12;13 p.m. registered nurse (RN)-A, verified R33's weight was up on 9/19/21, and stated the physician should have been notified, but it appeared it was not done. RN-A stated the physician notification and follow up should be documented in R33's progress notes and stated they were not. RN-A further stated the weights are documented in the medication administration record (MAR) and there should be directions to call the physician if the weight is up a certain amount.

On 9/24/21, at 12:33 p.m. the director of nursing (DON) stated if R33's weight had not been recorded on 9/2/21, but R33 went to dialysis on that Thursday, to make up for Wednesday's missed dialysis that had been planned. The DON stated it should have been documented in R33's EMR. The DON stated if R33's weight had shown an increase, such as on 9/19/21, he would try different scales and if R33 had a significant weight increase, he would call the physician, and stated R33's weights could not have been correct on 9/19/21, even though they had been checked three times. The DON stated he would expect documentation and verified there was no documentation of follow up taken for R33's weight increase on 9/19/21, and would have expected follow up, including calling the physician, even if it was an error.

The undated facility policy and procedure for Weight Assessment and Intervention, lacked direction for follow-up on significant acute weight

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changes with parameters for notification of the physician.

R10's Admission Record printed 9/24/21, indicated R10's diagnoses included atherosclerotic heart disease (damage or disease in the heart's major blood vessels), dementia, paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), type 2 Diabetes Mellitus, personality disorder, depression, anxiety disorder, and chronic pain.

R10's significant change Minimum Data Set (MDS) dated 7/9/21, indicated R10 was cognitively intact and was independent with activities of daily living (ADL) and did not reject cares. R10's MDS further indicated she required supervision with eating and was receiving insulin injections each of the seven days of the assessment period.

R10's Order Summary Report printed on 9/24/21, indicated R10 had orders for Humalog (a fast acting insulin used to treat diabetes) 100 units per milliliter (ml) twice daily as needed for a blood glucose greater than 400 in addition to scheduled dosing. If an as needed dose is given staff were directed to re-check blood glucose in one hour and call the provider if the blood glucose remained greater than 400. Orders did not address frequency of checking blood glucose.

R10's care plan revised on 5/12/21, addressed altered nutritional status related to Diabetes Mellitus type 2. The care plan directed staff to "monitor blood sugars as ordered."

R10's insulin administration record dated 9/1/21,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET DULUTH, MN 55811**

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F 684	Continued From page 25	F 684		

through 9/30/21, for Humalog insulin five units as needed twice daily indicated the following:

On 9/1/21, at 1:28 p.m. R10's blood glucose reading was 419. R10's blood glucose was not re-checked in one hour, it was checked again at 7:07 p.m. and was 401. R10's blood glucose was not re-checked in one hour.
On 9/5/21, at 1:45 p.m. R10's blood glucose was 405, it was not re-checked in one hour.
On 9/10/21, at 8:28 p.m. R10's blood glucose was 442, it was not re-checked in one hour.
On 9/12/21, at 1:05 p.m. R10's blood glucose was 404, it was not re-checked in one hour. It was however checked at 3:57 p.m. and was 515. There was no evidence that the as needed insulin was given or that the provider was contacted.
On 9/19/21, at 12:55 p.m. R10's blood glucose was 469, it was not re-checked in one hour.
On 9/21/21, at 1:44 p.m. R10's blood glucose was 425, it was checked at 3:22 p.m. (not re-checked within one hour). R10's blood sugar was 418, there was no evidence that the provider was notified.
On 9/22/21, at 1:09 p.m. R10's blood sugar was 405, it was re-checked at 2:08 p.m. and was 405, there was no evidence the provider was notified.

Nurses notes for September 2021, were requested but not provided.

On 9/23/21, at 10:09 a.m. the director of nursing (DON) verified staff were not following the provider's order for as needed insulin. The DON reviewed R10's progress notes and did not find nurse's notes for the blood glucose readings that were greater than 400, evidence that the blood glucose was re-checked, or that the provider was notified.

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F 684	Continued From page 26 On 9/23/21, at 12:27 p.m. the nurse practioner (NP) verified she would expect staff to follow the order for as needed insulin. She would have expected staff to re-check the blood glucose in one hour and notify the provider if the reading was greater than 400. The facility policy on insulin therapy was requested but not provided.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen tubing and nebulizer tubing was changed, dated and kept off the floor to prevent cross-contamination and infection for 1 of 1 residents (R35) reviewed for respiratory care. Findings include: R35's Admission Record printed 9/24/21, indicated R35's diagnoses included dementia, chronic obstructive pulmonary disease (COPD), shortness of breath, and chronic kidney disease.	F 695	F695 R35□s nebulizer and oxygen tubing were changed and dated on a weekly basis; this will be completed every Thursday to ensure compliance. All residents on oxygen or who utilize nebulizer equipment have the potential to be affected by this practice. All residents who are on oxygen or have a nebulizer will have a bag attached to their nebulizer, concentrator, or oxygen tank.	11/4/21

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F 695	Continued From page 27 R35's Order Summary Report printed 9/24/21, indicated R35's physician orders included: -Ipratropium-Albuterol Solution 0.5-2.5 mg/3 ml-inhale 3 ml orally four times a day for COPD and follow up after nebulizer, ordered 7/28/21. R35's care plan initiated 12/5/17, indicated R35 had an altered respiratory status with difficulty breathing, and all nebulizer treatments were on hold 10/13/20, due to potential aerosolization of COVID. R35's Treatment Administration Record (TAR) indicated R35 received a nebulizer treatment on 9/19/21, 9/21/21, 9/22/21, 9/23/21, 9/24/21, 9/25/21, and 9/26/21. R35's TAR and progress notes lacked evidence that R35 received oxygen during the month of September, or that R35 had a change in respiratory status. R35's nurse practitioner visit progress note dated 7/28/21, indicated R35 was seen for labored breathing, dusky appearance, increased respirations, tachycardia and oxygen desaturation to 82%; a nebulizer treatment was ordered at that time. Oxygen therapy was ordered as needed to keep oxygen saturation levels above 88%, along with other medications for her comfort. On 9/20/21, at 1:38 p.m. oxygen tubing and cannula were observed on the floor, hooked up to a portable oxygen tank in R35's room, and was not dated. Nebulizer tubing, hooked up to the nebulizer also was not dated.	F 695	The tubing will be stored in the bag when not in use. All nebulizer and oxygen tubing will be changed and dated every Thursday using a colored label. The task will be listed as a treatment for each resident that falls under the established parameter. All licensed staff and TMAs will be educated on this practice no later than 11/4/2021. The Director of Nursing, ADON, or designee will audit 5 residents with oxygen or nebulizer tubing per week x 30 days, 3 residents with oxygen or nebulizer tubing per week x 30 days, and 2 residents with oxygen or nebulizer tubing per week x 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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F 695	Continued From page 28 On 9/22/21, at 9:27 a.m. R35 was sitting in the hallway by the nurses desk, and was noted to have some respiratory symptoms with shortness of breath. On 9/22/21, at 9:35 a.m. the director of nursing (DON) stated they had been trying to get R35 into her room to give her a nebulizer treatment, but she was refusing to go to her room. Different staff were observed to approach R35 to try to convince her to go to her room. On 9/22/21, at 9:37 a.m. R35's oxygen tank was in her room, cannula and tubing were still on the floor in the same position as it was on 9/21/21. R35's nebulizer tubing was attached to the nebulizer and the end that the medication cup would attach to, was touching the floor. On 9/24/21, at 12:43 p.m. the DON stated if oxygen tubing was on the floor, it should be thrown out and a new one put on and dated. On 9/24/21, at 2:36 p.m. R35's oxygen tubing and cannula were still on the floor and were not dated. Nebulizer tubing was not on the floor any longer, but was not dated. The DON verified the findings at that time, and stated they needed to be changed and dated. The facility policy and procedure for oxygen tubing was not received.	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 725		11/4/21

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provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide staffing at levels to ensure baths were routinely provided as scheduled and per resident preferences for 2 of 9 residents (R33 and R27) reviewed for bathing.

Findings include:

R33's Admission Record printed 9/24/21, indicated R33's diagnoses included weakness, end-stage renal disease, diabetes, and spinal stenosis (condition in which the spinal column narrows and compresses the spinal cord).

F725

R33 and R72 are scheduled for biweekly baths per their preference. Residents 10, 27, 37, and 45 are scheduled for weekly baths(preference). The facility will ensure their baths are completed. If necessary, the nursing assistant will report to the charge nurse that they need assistance with completing the bath. The charge nurse will reassign or rearrange the bath schedule to ensure it's completed. If necessary, ancillary staff can be called

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F 725	Continued From page 30 R33's quarterly Minimum Data Set (MDS) assessment dated 8/28/21, indicated R33 was cognitively intact, was able to clearly communicate her needs, and required transfer assistance for bathing. R33's care plan initiated 11/7/19, indicated R33 required limited assistance of one staff with bathing or showering. R33's care plan did not address R33's preferences for frequency of bathing or showering. R33's care guide directed staff to provide limited assistance with bathing or showering for R33. R33's care guide failed to direct frequency of R33's baths. R33's bathing documentation provided 9/24/21, indicated R33 had a bath or shower on 8/26/21, 9/2/21, and 9/9/21. R33 required physical assistance in part of bathing for 2 baths and was independent with bathing for one bath. R33's bathing documentation lacked evidence of a bath provided between 9/9/21 and 9/24/21. On 9/20/21, at 6:14 p.m. R33 stated she would prefer two baths weekly, but has been told she could only get one, due to there not being enough staff. On 9/24/21, at 12:33 p.m. the director of nursing (DON) stated they offered a bath once a week at a minimum, but if a resident wanted a second bath, they do have staffing issues so are unable to always accommodate a second bath. The DON stated R33 had not been in the facility on two Thursday mornings, so may not have received a bath. The DON stated if they do not	F 725	upon to assist. All residents have the potential to be affected by this practice. All residents bathing schedules will be reviewed upon admission and during the residents quarterly care conference to ensure that their preferences are being met. The Director of Nursing, ADON, or designee will audit 5 residents per week to ensure they have received their scheduled bath x 30 days, 3 residents per week x 30 days, and 2 residents per week x 30 day for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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have enough staff to do baths one day, they will do the bath the next day.

The facility policy and procedure for Resident Bathing dated 3/20, directed each resident would be assigned a weekly bathing day, and the resident may choose a day or afternoon bath. The facility policy further indicated some residents may request a second bath day added to their schedule, and if so, the facility would do all they could to accommodate the resident's request. If a bath could not be completed due to staffing changes, the facility would reschedule the bath the next day or another day per the resident's request.

On 9/22/21, at 2:01 p.m. the resident council minutes were reviewed with permission from R5.

The September and March 2021, minutes documented concerns about staff shortages both in the kitchen and with nursing. The minutes also documented concerns about food being late, cold, and with staff turnover.

During the resident council 9/23/21, four residents (R10, R27, R37, R45) expressed concern that they were not receiving their baths as scheduled because of lack of staff.

R27's Admission Record printed 9/24/21, indicated R27's diagnoses included moderate persistent asthma, pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and heart causing shortness of breath, dizziness, and chest pressure), depression, polymyalgia rheumatica (an inflammatory disorder causing muscle pain and stiffness),

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obstructive sleep apnea (intermittent airflow blockage during sleep), and muscle weakness.

R27's quarterly Minimum Data Set dated 8/11/21, indicated R27 was cognitively intact and was independent with her activities of daily living (ADL). Bathing was not addressed on the MDS. R27's annual MDS dated 5/12/21, indicated R27 required help in part of bathing activity.

On 9/20/21, at 12:52 p.m. R27 stated it was her preference to have a bath twice a week. R27 stated the week before on 9/16/21, she did not get a bath and no one came to tell her she would not be able to have her bath as planned.

The facility AM Bath Schedules, undated, indicated R27 was scheduled for a bath on Thursday and Sunday.

The bathing task look back for 30 days dated 9/5/21, through 9/23/21, indicated R27 did not receive a bath on 9/2/21, 9/9/21, or 9/16/21.

On 9/23/21, at 4:30 p.m. the director of nursing (DON) stated if nothing was marked on the bathing task sheet it would have meant a bath was not given. The DON further stated it would have been his expectation if staff were short and not able to give a bath they would offer to give a bath the next day. The DON was not sure if the electronic medical record (EMR) would allow documentation of an unscheduled bath.

On 9/24/21, at 9:32 a.m. nursing assistant (NA)-C stated it has been stressful when "everyone is calling for help" and there are only two of them. She stated there should be two NA's on each floor and when there is only one on each floor

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F 725	Continued From page 33 they try to get everything done, but sometimes can't get the baths done. The facility policy titled Resident Bathing 3/20/20, indicated residents could request a second bath and the facility would do all they could to accommodate the request. In such cases when a bath cannot be performed due to an emergency or staffing change. The facility will reschedule the bath the next day, or on another day the resident requests.	F 725		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		11/4/21

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F 756	Continued From page 34 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 facility failed to ensure the consultant pharmacist recommendations were followed up on timely for 1 of 5 residents (R17) reviewed for unnecessary medications. Findings include: R17's Admission Record printed 9/24/21, indicated R17's diagnoses included diabetes, chronic kidney disease, osteomyelitis, hypertension, major depressive disorder, chronic pain, and gastro-esophageal reflux disease (GERD). R17's comprehensive annual Minimum Data Set (MDS) assessment dated 7/15/21, indicated R17 had received insulin, antianxiety medication, antidepressant medication and opioid medications daily. R17's care plan identified R17's diagnosis of depression and directed nursing to administer medications as ordered and to monitor for side	F 756	F756 Per the consulting pharmacist recommendations, R17□s HGB-A1C has been completed and reviewed by the MD. Nursing has reviewed the risk vs. benefit for use of the antipsychotic medications with the resident□s primary healthcare provider and documentation for continued use is noted in the provider□s progress notes. An AIMS test was completed and will be completed quarterly. After facility review of the consulting pharmacist recommendations, it was identified that the pharmacist did not send recommendations for October 2020. The pharmacist has since sent those recommendations to the facility. All recommendations have been followed up on. All residents have the potential to be affected by this	

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F 756	Continued From page 35 effects and effectiveness of medications. R17's Medication Administration Record (MAR) indicated R17 received: -esomeprazole magnesium capsule delayed release (DR) give 40 mg by mouth twice daily for GERD, started 7/1/20. -metoclopramide HCl 5 mg given twice daily for GERD R17's MAR further indicated R17's medication administration time had been changed to meal times on 9/12/21. R17's consultant pharmacist review dated 9/22/20, indicated identified irregularities. The consultant pharmacist recommended checking a Hemoglobin A1C (lab test for diabetes) at least annually, and if checked recently to provide a copy of the results no later than 30 days. The pharmacist's recommendation form had not been responded to. R17's consultant pharmacist review dated 11/09/20, indicated identified irregularities. The consultant pharmacist recommended checking a Hemoglobin A1C (lab test for diabetes) at least annually, and if checked recently to provide a copy of the results no later than 30 days. The pharmacist's recommendation form was not available. R17's consultant pharmacist recommendation form dated 12/22/20, recommended checking a Hemoglobin A1C (lab test for diabetes) at least annually, and if checked recently to provide a copy of the results no later than 30 days. The pharmacist's form indicated the provider responded on 2/2/21, and indicated R17's	F 756	practice. The DON, ADON, or designee will identify a specific day of the month to review pharmacy consultant recommendations including speaking to the consultant directly to ensure compliance. During the monthly review, nursing will review the pharmacist identification of irregularities. The Director of Nursing, ADON, or designee will audit 20 residents per month x 90 days to ensure that pharmacy consultant recommendations are addressed. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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Hemoglobin A1C was monitored routinely, but did not provide a date when it had been checked, did not order a Hemoglobin A1C annually, and had not responded within the 30 day time period, as the consultant pharmacist requested.

R17's consultant pharmacist recommendations dated 8/11/21, indicated R17 received metoclopramide which could increase the risk of extrapyramidal (physical symptoms, including tremor, slurred speech, movement disorder making it hard to stay still, involuntary muscle contractions, anxiety, distress, paranoia, and bradyphrenia, that are primarily associated with improper dosing of or unusual reactions to antipsychotic medications) side effects and tardive dyskinesia (a condition with uncontrolled movements), and recommended nursing to address clinical rationale and risk versus benefit documentation for continued use of this medication. In addition, the recommendation directed nursing to monitor for tardive dyskinesia with an AIMS (Abnormal Involuntary Movement Scale) or DISCUS (tools to monitor for and identify potential symptoms of tardive dyskinesia) at least every six months, and complete the assessment within 30 days.

R17's assessments in the electronic medical record (EMR) reviewed on 9/27/21, indicated an AIMS (Abnormal Involuntary Movement Scale) or DISCUS had not yet been completed.

R17's most recent AIMS assessment was on 7/1/20, with a score of zero, indicating R17 did not have any signs or symptoms of tardive dyskinesia at that time. R17's AIMS assessment was greater than a year ago.

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F 756	Continued From page 37 On 9/23/21, at 11:52 a.m. R17 stated she has had no side effects related to medications. On 9/24/21, at 12:47 p.m. the assistant director of nursing (ADON) stated she had to call the consultant pharmacist for the October 2020 medication reviews, as she did not have them available. The ADON stated they follow the consultant pharmacist recommendations, and stated if it was a nursing recommendation, they put it on the electronic medication administration record (eMAR). The ADON verified R17's eMAR lacked some of the consultant pharmacist recommended directions. The ADON verified an AIMS had not been completed within 30 days for R17. On 9/24/21, at 1:07 p.m. the director of nursing (DON) stated the expectation was for the consultant pharmacist reviews to be reviewed and addressed within the time frame recommended. The facility policy and procedure for Pharmacy Consultant dated 3/20, directed the DON, ADON, or designee to address any irregularities found by the pharmacist in a timely manner.	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		11/4/21

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F 761	Continued From page 38 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store each resident's topical treatment creams and ointments to prevent cross contamination for 11 of 11 residents (R4, R8, R10, R15, R19, R49, R9, R12, R26, R33, and R40) whose treatment creams were observed together in the medication treatment cart. In addition, the facility failed to ensure yellow top and blue top lab tubes for blood draws were not expired. This had the potential to affect any residents who would have blood samples drawn using yellow top or blue top lab tubes. Findings include: R4's diagnosis report printed 9/27/21, indicated R4 had congestive heart failure (CHF), and rheumatic mitral valve disease, and erythema intertrigo (skin inflammation or infection).	F 761	F761 All treatments tubes, powders, gels were placed in labeled individual resident containers for each of the medication carts (4) on 9/24/2021. There is a container for the identified residents: R4, R8, R10, R15, R19, R49, R9, R12, R26, R33, R40, and all other residents. This will prevent potential cross-contamination. All expired lab tubes were removed from the medical storage room on 9/24/21. All residents have the potential to be affected by this practice. All residents now have a plastic container with their respective treatments in the medication carts. The lab draw cart will be audited by the DON, ADON, or designee	

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F 761	Continued From page 39 R4's Order Summary Report indicated R4's physician orders included: - triamcinolone acetonide ointment 0.1% (used to treat the itching, redness, dryness, crusting, scaling, inflammation, and discomfort of various skin conditions); apply to bilateral (both sides of the body) lower extremities topically every evening shift, every Tuesday and Friday for skin management. -Apperceive with lidocaine cream 4%, (for pain relief); apply to right shoulder topically three times a day. -Vanicream cream (emollient), apply to bilateral lower extremities and back topically every day and evening shift for itching apply twice daily or increased redness on bilateral lower extremities. R8's Admission Record printed 9/27/21, indicated R8's diagnoses included autoimmune thyroiditis (inflammation of the thyroid). R8's Order Summary Report printed 9/27/21, indicated R8's physician orders included: -triamcinolone acetonide cream 0.1% apply to left lower extremity topically every evening shift for skin management as needed, and apply to lower extremities topically as needed for when redness and/or rash re-occurs. R10's Admission Report printed 9/24/21, indicated R10's diagnoses included CHF, diabetes, chronic kidney disease, pruritus (itching). R10's Order Summary Report printed 9/24/21, indicated R10's physician orders included: -Lotrisone cream 1.0-0.5% (used to treat fungal skin infections) perineal area and pannus as	F 761	each week to ensure there are no expired lab supplies. All licensed staff and TMAs will be educated on this practice no later than 11/4/2021. The DON, ADON, or designee will audit all medication carts and the lab draw cart weekly x 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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F 761	Continued From page 40	F 761		

needed for redness.
-Voltaren gel 1%, apply to right shoulder four times daily for pain.

R15's Admission Record printed 9/27/21, indicated R15's diagnoses included diabetes, injury to the muscles and tendons of the rotator cuff of the right shoulder.

R15's Order Summary Report printed 9/27/21, indicated R15's physician orders included:
-clotrimazole cream 1% (used to treat fungal skin infections); apply to abdominal fold topically as needed for skin management flare ups.
-nystatin powder apply to affected areas topically every 12 hours as needed for itching.
-miconazole powder (antifungal), apply to under breast and abdominal folds topically as needed for redness or yeast, nystatin cream or powder as needed.

R19's Admission Record printed 9/27/21, indicated R19's diagnoses included CHF, diabetes, chronic kidney disease, and gout.

R19's Order Summary Report printed 9/27/21, indicated R19's physician orders included:
-hydrocortisone cream 1% (used to treat itching) apply to affected areas topically every 6 hours as needed for itching.
-lacked orders for nystatin

R49's Admission Record printed 9/27/21, indicated R49's diagnoses included chronic obstructive pulmonary disease, malignant neoplasm of bronchus or lung, and pain.

R49's Order Summary Report printed 9/27/21, indicated R49's physician orders included:

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F 761	Continued From page 41	F 761		

-camphor-menthol lotion 0.5-0.5%, apply to itchy areas topically as needed for itching daily as needed.
-hydrocortisone cream 1%, apply topically as needed topically every 12 hours as needed for itch
-Voltaren gel 1% (diclofenac sodium), apply to right shoulder topically four times daily for pain until 9/30/21, and every 6 hours as needed for pain

R9's Admission Record printed 9/27/21, indicated R9's diagnoses included chronic obstructive pulmonary disease, and diabetes.

R9's Order Summary Report printed 9/27/21, indicated R9's physician orders included:
-nystatin cream 100000 unit/gram, apply to low abdomen and groin topically every day and evening shift for red irritated and yeasty areas twice daily until resolved the discontinue or change as needed and discontinue when out.
-Nystatin powder 100000 unit/gram, apply to rash in folds topically as needed for rash in abdominal folds, under breasts and groin.
-trolamine salycylate cream 10%, apply to affected area topically as needed for pain , apply to affected area four times daily as needed.

R12's Admission Record printed 9/27/21, indicated R12's diagnoses included chronic respiratory failure, diabetes, chronic kidney disease, chronic gout, and history of infectious and parasitic diseases.

R12's Order Summary Report printed 9/27/21, indicated R12's physician orders included:
-triamcinolone acetonide cream 0.1%, apply to rash topically as needed for rash, apply twice

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F 761	Continued From page 42	F 761		

daily.
-Voltaren Gel 1%, Apply one application tansdermally every 6 hours as needed for pain to shoulder 4 times daily as needed.

R26's Admission Record printed 9/27/21, indicated R26's diagnoses included cerebral infarction (stroke), sick sinus syndrome (heart arrhythmia), and history of breast cancer.

R26's Order Summary Report printed 9/27/21, indicated R26's physician orders lacked current orders for topical treatments.

R33's Admission Record printed 9/24/21, indicated R33's diagnoses included end stage renal disease, diabetes, artificial hip, and atrial fibrillation (irregular heart beat).

R33's Order Summary Report printed 9/24/21, indicated R33's physician orders included lidocaine-
-prilocaine 2.5-2.5%, apply to affected areas topically every 6 hours as needed for numbing cream.
-lidocaine cream 5%, apply to affected area of pain topically every 24 hours as needed for pain

R40's Admission Record printed 9/27/21, indicated R40's diagnoses included history of COVID-19, and hypothyroidism (low thyroid hormone production).

R40's Order Summary Report printed 9/27/21, indicated R40's physician orders included:
-hydrocortisone cream 1%, apply to perineal area topically as needed for irritation of skin tags twice daily as needed.
-Biofreeze gel 4%, apply to right hip topically two

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F 761	Continued From page 43	F 761		

times daily for pain
-Preparation H cream 1%, apply to hemorrhoids topically as needed

On 9/24/21, at 2:55 p.m. during a tour with licensed practical nurse (LPN)-C, the medication cart on second floor was observed to have several topical treatment creams, powders, and ointments for different residents stored together in the same compartment. Some tubes were in baggies and some tubes were loose in the compartment. LPN-C stated they would take the baggies to the resident rooms when using the topical treatment and verified there was a risk of cross-contamination and infection when they were stored together in the medication cart.

-R4 had triamcinolone tubes and desonide (treat the redness, swelling, itching, and discomfort of various skin conditions) in a baggie.
-R8 had triamcinolone in a baggie.
-R10 had estrace (hormone vaginal cream) and lotrimin cream in a baggie.
-R15 had clotrimazole and nystatin (used to treat fungal skin infections) tubes in a baggie.
-R19 had nystatin tube in a baggie.

Topical treatments stored loose in the same compartment included:
-An unlabeled tube of hydrocortisone cream was loose in the compartment. LPN-C stated R49 and R9 used to use the hydrocortisone cream.
-Used unlabeled tubes of ciclopirox olamine and nystatin were loose in the compartment.
-unlabeled diclofenac sodium topical gel (used to treat pain, inflammation, swelling, and stiffness).
-R9's nystatin and nystatin powder
-R12's triamcinolone cream
-R26's diclofenac sodium cream

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F 761	Continued From page 44 -R33's triamcinolone cream and lidocaine cream (used to treat itching and pain from skin conditions) -R40's hydrocortisone and nystatin powder On 9/24/21, at 2:55 p.m. during the same tour of tour of medication and treatment storage rooms, LPN-C verified 75 blue-top lab tubes had expired on 7/31/21, and 85 yellow-top lab tubes had expired on 4/30/21. On 9/24/21, at 3:30 p.m. the director of nursing (DON) stated the hospital lab usually draws labs and these were their lab tubes, but verified they should not be expired. The DON stated he wasn't sure if any residents had labs drawn using those tubes. On 9/24/21, at 3:35 p.m. the assistant director of nursing (ADON) verified there would be a risk of cross-contamination with the topical treatments stored together. On 9/24/21, at 3:40 p.m. the DON verified they needed to separate topical treatments due to risk of cross-contamination and infection. The facility policy and procedure for Storage of Medications undated, directed resident medications to be stored separately from each other to prevent the possibility of mixing medications between residents.	F 761		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 790		11/4/21

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F 790	Continued From page 45 §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental status	F 790	F790	

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F 790	Continued From page 46 was assessed, and routine dental services were offered for 1 of 1 residents (R35) reviewed for dental status. Findings include: R35's Admission Record printed 9/24/21, indicated R35's diagnoses included dementia without behavioral disturbance, osteoporosis, and chronic obstructive pulmonary disease. R35's quarterly Minimum Data Set (MDS) assessment dated 8/28/21, indicated R35 had a severe cognitive deficit, understood others, was understood by others, had no refusal of care behaviors, and required extensive assist with personal hygiene. R35's comprehensive annual MDS, dated 11/25/20, indicated R35 had no broken dentures and no dental concerns as listed on the MDS. R35's care plan initiated 1/20/16, indicated R35 had a missing upper denture plate on 9/25/20, and a missing lower partial on 3/4/21. R35's care plan further indicated R35 had two teeth on the lower gum and had a history of misplacing her dentures. R35's dental assessment dated 11/25/20, indicated R35 had no broken dentures, was not edentulous (without teeth), did not have abnormal mouth tissue, no obvious or likely cavity or broken natural teeth, no inflamed or bleeding gums or loose natural teeth, no mouth or facial pain or discomfort or difficulty chewing. R35's care conference notes on 9/21/21, indicated the resident representative was in	F 790	A care conference with R35□s daughters (legal guardian) will be held no later than 11/4/21. At the care conference,R35's dental status will be discussed and a plan of action will be documented in her progress notes. All residents have the potential to be affected by this practice. The care conference template will be altered to include a specific section to document vision and dental services needed such as appointments, new dentures, glasses, etc. All residents will have documentation indicating their plan of action for dental and vision services in the note. The Availability of Services, Dental policy has been updated to identify the circumstances at 483.55(a)(3). All parties will be educated on the change to care conference template; Social Services, Life Enrichment, and Nursing (designee □ DON or ADON) no later than 11/4/2021 The Director of Nursing, ADON, or designee will audit 5 residents for documentation of dental and vision services per week x 30 days, 3 residents per week x 30 days, and 2 residents per week x 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period.	

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F 790	Continued From page 47 attendance via phone; the notes lacked indication that dental services were offered to R35. R35's care conference notes dated 3/16/21, indicated it was held via phone with the resident representative and lacked evidence of offering of dental services. R35's progress notes from 1/21/21, to 9/21/21, lacked documentation regarding R35's dental status and reason for lack of dental services or offering of dental services. On 9/20/21, at 1:38 p.m. R35 was observed to have missing teeth on lower gum, but upper teeth were not able to be viewed at that time. On 9/24/21, at 12:43 p.m. the director of nursing (DON) stated he would expect dental status and dental services to be discussed quarterly in care conference and dental status to be assessed for the MDS. The facility policy and procedure for dental services, indicated routine and 24-hour emergency dental services were provided to residents through a licensed dentist that came to the facility monthly, a referral to a personal dentist or community dentist. If dentures were damaged or lost, residents would be referred for dental services within 3 days. If referral not made within 3 days, documentation would be completed regarding what was being done to ensure adequate nourishment and hydration, while waiting for dental services, and the reason for delay.	F 790		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b)	F 802		11/4/21

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F 802	Continued From page 48 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure there were enough dietary staff to ensure that the kitchen cleanliness was maintained, food was stored and handled in a safe maner. This had the potential to affect all 48 residents residing in the facility who consumed food from the kitchen. Findings included: On 9/20/21, at 11:57 a.m. the administrator stated they have been without a dietary manager for "about a week or two" and had recently contracted with a dietary manager consultant (DMC)-A from out of state until he could hire a full-time dietary manager.	F 802	F802 1. No residents were negatively affected by the alleged deficient practice. 2. All residents receiving meals in the facility have the potential to be affected by the alleged deficient practice. 3. The facility continues to recruit for facility needs, evidence by job postings, interviews, and new hiring of new hires. 4. The facility has contracted a culinary operations consultant company, Quality Culinary Solutions, LLC, to implement standards in dietary, to ensure compliance. The culinary operations consultant is available via phone, email, and text daily and with on-site dietary training and	

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F 802	Continued From page 49 During the initial kitchen tour on 9/20/21, at 12:00 p.m. with cook (C)-A: -The double sink located to the left of the rear entrance of the kitchen had a bin with individualized cereal containers sitting on the flat part of the metal sink, along with an opened box of bananas, various paperwork and miscellaneous office supplies, and a variety of clear storage containers. Two plastic white bins were turned upside down drying over the sink compartments. -Garbage cans next to the steam tables and clean dishes were uncovered. -The sink next to the food prep station had a large black tub drying upside down directly on the side of the metal sink along with wire racks, a gray bucket, metal serving pans, a clear plastic storage container, and a saucepan placed upside down directly on top of large plastic bin. -Throughout the kitchen floor there were areas of dried food/fluid spillage, and small particles of foods. -Dry spices above the stove had film build up on the outside of the containers. -Hood vents above the oven/stove were visibly dirty with brown particles and dust build up. -The stove top griddle and gas burners had burned food debrief and grease build up. -The metal storage shelving below the coffee maker with the sliding doors where strainers and maroon round container were kept had food	F 802	oversight. 5. A new hire of a certified dietary manager will begin on November 8, 2021. 6. All dietary staff will attend and in-person training session on November 1, 2021, that will entail safe food handling, infection prevention/hand hygiene, and food borne illnesses. This requires all dietary staff to demonstrate proper hand hygiene to the culinary operations consultant at the time of the in-service. Training record will be maintained in the dietary services office. " All observations and auditing tools will be initiated starting November 1, 2021. " Visual observation of staff performing food production and taking temperature readings appropriately before meal service and at the end of meal service will be completed daily and logged on the food temperature log, by the culinary operations consultant or dietary designee. Logs will be kept monthly in the dietary office. " Safe food handling will be done via food temperature log audits daily by dietary designee. " Daily temperature logs will be completed three times daily for the kitchen walk-in cooler and kitchen walk-in freezer via an internal thermometer and an external thermometer and will be audited daily by designated dietary staff member. " Hand hygiene audits will be completed daily per shift by designated dietary	

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F 802	Continued From page 50 debrief and food/liquid spillage on the shelf. -A three-tiered metal cart which stored the blender, puree machine, knife cutter, and hot pads had dried food splattered on top of the shelf, along with a white powered substance and crumbs of food. The blender base was dirty with splatters of food and dust build up and the Ultra Robot puree machine had brown dried spillage on the front and sides of the base. On 9/20/21, at 1:12 p.m. the dietary aide (DA)-A stated they had been without a dietary manager for about a month and had been short staffed and working with one to two dietary aides in the kitchen. DA-A further stated C-A had been working double shifts every day because there was no dietary manager, they were short cooks, and the other cook was on vacation. On 9/20/21, at 1:19 p.m. C-A stated she was hired as a cook a couple months ago. C-A stated they did not have a dietary manager and have not had a consistent dietary manager in several months so C-A was doing it all. C-A further stated she normally worked 11 a.m. to 7:00 p.m. but due to lack of cooks, C-A was working everyday cooking breakfast, lunch, and dinner meals. C-A further stated since they did not have enough dietary staff, daily kitchen tasks were not being done like daily basic cleaning, logging refrigerator and freezer temperatures, placing food orders, kitchen organization and for convenience and lack of time, meals were not prepared from scratch and she was using canned and prepackaged foods. C-A verified there was a substantial amount of dust and grime build up on the hood vents located over the stove and oven, the small appliances were dirty and not being	F 802	supervisor. The audits will be kept in the dietary office. 7. All policy and procedures pertaining to F 802 will be reviewed and revised as necessary by culinary operations consultant. The auditing tool will be audited 3X per week for 30 days, then 2X per week for 30 days, then 1X per week for 30 days for a total of 90 days to ensure completion of requirements. The results of the audits will be reported at the monthly QAPI meeting. The dietary manger or designee is responsible for the monitoring.	

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wiped down after each use, and the kitchen could use an overall good cleaning and organization. C-A stated the kitchen should be staffed with three dietary aides, but they were usually staffed with one to two dietary aides and they were doing the best they could with kitchen staff they had.

On 9/22/21 at 7:19 a.m. continuing the kitchen tour with C-A:
-The walk in freezer had a total of eight boxes frozen foods including chicken, Crustables, white turkey patties, and tubes of hamburger stored on the floor of the freezer.

-Small dishes of mandarin oranges were undated and uncovered in the walk in cooler.

-A block of opened butter was undated in a bowl on a shelf (covered) next to stove?

-A towel was on the wood block counter top with two clear plastic tubs, a small cutting board, a measuring cup, and knives drying directly on the towel.

-The outer surfaces of the metal cabinets, walk in cooler, refrigerators were dirty with multiple finger prints and smudges on the doors, dried drippings of food/fluid and food crumbs on the medal shortage shelves.

-In the walk-in cooler on the same wired rack was an undated Ziploc plastic baggie of cooked bacon, an opened, undated package of sliced ham, and an undated covered bowl of cottage cheese. On a three-tiered shelf was an undated, opened packaged of cubed chicken next to a box of celery.

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-The outside of the sugar and flour medal bins and lids had a buildup of flour residue and a blue cup with a handle was in the flour bin.

-A clear water picture was being dried upside down directly on the side of the two-sided compartment sink near the prep station.

On 9/22/21, at 9:42 a.m. DA-A was observed putting dirty dishes through the dishwasher and carts were observed with dirty dishes going past and stored next to uncovered clean racks of cups and plates.

On 9/22/21, at 9:05 a.m. C-A verified food was not being stored correctly in the walk in cooler and food was put were it fit. C-A stated there was not enough staff in the kitchen, time, or space in the walk in cooler to organize food properly. C-A stated she was aware food should not be stored on the freezer floor and further stated there was not enough shelving space to properly store the frozen foods.

On 9/22/21, at 9:52 a.m. DA-B stated they did not have a cleaning schedule and stated, "we try and clean as we go." DA-B further stated there was not time to deep clean or wipe down shelving, wipe the outside of the metal cabinets or coolers because they were short staffed in the kitchen. DA-B verified the small appliances were soiled with dried food spillage, crumbs and dust build up. DA-B also verified the metal storage shelves for clean dishes had food crumbs and splattered food or fluid substance on the shelves, and the kitchen floors needed to be swept and mopped.

On 9/22/21, at 11:13 a.m. the environmental director (ED)-A stated the kitchen hood and vent

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was last cleaned on 6/2/21, by Northland Fire and Safety and was aware the hoods were overdue for cleaning. ED-A verified the kitchen stove/oven hood vents needed to be clean and were full of dust and grease build up. The ED-A stated the stove and oven were not on the quarterly cleaning schedule, and he relied on the cooks to let him know when the stove and oven needed cleaning. The ED-A stated maintenance tried to help the kitchen staff by cleaning the walls and floors, but it had been a challenge keeping up cleaning the kitchen due to not having enough staff.

During second kitchen observation on 9/22/21, at 11:25 a.m.:
-The outside of the sugar and flour medal bins and lids had a buildup of flour residue and a blue cup with a handle was in the flour bin.

-A clear water pitcher was being dried upside down directly on the side of the two-sided compartment sink near the prep station.

On 9/23/21, at 10:16 a.m. the administrator stated they started using canned foods after the dietary manager left and not having enough dietary staff to help in the kitchen. The administrator further stated he was aware residents were not getting special diets when using canned and pre-packed foods. The administrator stated he talked to the consultant when the dietary manager left, but he had not been in there yet. The administrator was aware they had problems in the kitchen and were working on them.

On 9/23/21, at 11:29 a.m. the DMC-A stated he was contacted a couple of weeks ago to help in the kitchen because the facility was without a

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dietary manager. The DMC-A stated he had not been in contact with the facility dietician or the cook at that time and this was his first on site visit. The DMC-C stated he took a brief walk through the kitchen and saw the kitchen was in bad shape and needed immediate interventions. The DMC-A stated food should not be stored on the floor to prevent possible contamination and clean dishes should be dried on racks allowing air to circulate and not a towel.

On 9/23/21, at 4:02 p.m. a follow up interview was conducted with DMC-A. DMC-A stated he was working on cleaning the food prep station, and overall cleaning and de-cluttering the kitchen. DMC-A further stated cleaning in the kitchen was overdue and verified the small appliances, floors, oven vents, walk in cooler, prep stations, counters, and shelves were unclean. DMC-A verified cleaning logs were not being kept, food temperatures were not being logged daily and fridge and freezer temps were not consistently logged. The DMC-A stated after dinner the coolers were going to be cleaned out and all the leftovers thrown out since cooked foods were not cooled properly before storing in the coolers. The DMC-A stated if cooked foods were not properly cooled, it had the risk of growing bacteria in the temperature danger zone which could cause severe illness. The DMC-A stated the kitchen staff had been without consistent leadership and staff needed a lot of education and training on proper food storage, safe food and dishware handling.

On 9/24/21, at 2:08 p.m. the administrator stated he was aware there were concerns with the cleanliness and organization of the kitchen, proper food handling, and food storage. The

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administrator further stated the current menu and preparation of foods did not meet prescribed therapeutic diets for the residents.

The facility policy Food Storage dated 2013, directed the following:
-Scoops for bulk foods were not to be stored in the food containers and kept covered in a protected area near the containers.
-Food items will be stored on the shelves.
-Food should be stored a minimum of six inches above the floor.
-Leftover food was stored in containers or wrapped securely, clearly labeled, dated and used within three days or discarded.
-Every refrigerator must be equipped with an internal thermometer.

The facility policy General Sanitation of Kitchen dated 2013, directed the following:
-Cleaning and sanitation tasks for the kitchen were to be recorded.
-Frequency for cleaning for each task would be defined.
-A cleaning schedule would be posted.

The facility policy Cleaning Dishes/Dish Machine dated 2013, directed the following:
-Allow dishes to air dry on the dish rack, do not dry with towels.
-Flatware should be presoaked prior to washing and washed twice.
-Thermal strips may be use as verification that the temperature is adequately hot.

The facility policy Cleaning Instructions: Food Preparation Appliances dated 2013, indicated small appliances (such as mixers and food processors) would be cleaned and sanitized after

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F 802	Continued From page 56 each use. The facility policy Cleaning Instructions: Cabinets and Drawers dated 2013, indicated cabinets and drawers would be free from food particles and dirt and should be clean at least twice a month. Cabinets and drawers were cleaned as needed when spills occurred. The facility policy Cleaning Instructions: Hoods and Filters dated 2013, indicated stove hoods and filters would be cleaned according to the cleaning schedule, or at least monthly.	F 802		
F 808 SS=E	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide therapeutic diets as prescribed by the physician for 22 of 22 residents (R2, R4, R6, R9, R10, R16, R17, R18, R19, R22, R24, R27, R28, R29, R30, R31, R33, R34, R37, R38, R44, and R47) reviewed for residents prescribed therapeutic diets. Findings include: R2's Admission Record printed 9/27/21, indicated	F 808	F808 1. All residents receiving meals in the facility have the potential to be affected by the alleged deficient practice. 2. All dietary staff will be trained by the Registered Dietician, and the use of menu extensions and properly serving therapeutic diets. This will include portion control, therapeutic liquids, and recipe production.	11/4/21

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F 808	Continued From page 57 R2's diagnoses included chronic diastolic heart failure, hypertension (HTN), hypo-osmolality (when levels of electrolytes, proteins, and nutrients in the blood are lower than normal), and hyponatremia (when the level of sodium in the blood is too low), arteriosclerotic heart disease and type two diabetes. R2's Order Summary Report dated 9/27/21, included dietary orders for a no added salt (NAS) diet, regular textured foods, and a fluid restriction of 1092 milliliters(ml) from dietary and 800 ml from nursing. R2's diet orders also included a yogurt daily, 12 ounces (oz) of vegetable juice in the morning (a.m.), 6 oz at lunch and dinner. R4's Admission Record printed 9/27/21, indicated R4's diagnoses included pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and heart), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), HTN, edema, stage three chronic kidney disease (a condition in which the kidneys do not function as well as they should), and Alzheimer's disease. R4's Order Summary Report dated 9/27/21, included dietary orders for NAS diet NAS. R6's Admission Record printed 9/27/21, indicated R6's diagnoses included aphasia (loss of ability to understand or express speech) following cerebral infarction (stroke), arteriosclerotic heart disease (damage or disease in the heart's major blood vessels), paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and presence of cardiac	F 808	3. Weekly communication will be scheduled between the consultant Registered Dietician and the Certified Dietary Manager. 4. New menu system including tray cards, recipes and menus to be implemented. All policy and procedures pertaining to F 808 will be reviewed and revised as necessary by culinary operations consultant. All residents diet orders have been reviewed by the Registered Dietitian and tray tickets have been updated with the prescribed diet. The diet report will be compared to the tray ticket weekly X 30 days to ensure diets are recorded accurately. Tray service of 10 residents with therapeutic diets will be monitored X one week for 30 days to ensure they are being served their prescribed diet, then 5 residents X 30 days, then 5 residents for 30 days for a total of 90 days. The dietary manager/designee is responsible for monitoring. The results of the audits will be reported at the monthly QAPI meeting.	

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pacemaker.

R6's Order Summary Report dated 9/27/21, indicated a physician's order dated 7/13/21, directed R6 to receive a cardiac, low fat, low cholesterol, three gram (gm) sodium diet.

R6's care plan dated 4/2/21, directed staff to provide and serve a heart healthy diet as ordered; and in addition, to monitor and record intake at every meal.

R6's quarterly progress note by the dietician dated 9/26/21, indicated R6 was being served a regular diet.

A copy of the facility diet card was requested for R6, the diet card showed R6 was receiving a regular diet.

On 9/22/21, at 8:51 a.m. R6's meal ticket was observed to be marked as a "regular diet".

R9's Admission Record printed 9/27/21, indicated R9's diagnoses included type two diabetes, hyperlipidemia, dementia, edema, HTN, and hypokalemia.

R9's Order Summary Report dated 9/27/21, included dietary orders for a consistent carbohydrate diet.

R10's Admission Record printed 9/24/21, indicated R10's diagnoses included arteriosclerotic heart disease, transient cerebral ischemic attack, dementia, paroxysmal atrial

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fibrillation, type 2 Diabetes Mellitus, personality disorder, depression, anxiety disorder, and chronic pain.

R10's significant change MDS dated 7/9/21, indicated R10 was cognitively intact. R10's MDS further indicated she required supervision with eating.

R10's Order Summary Report dated 9/24/21, indicated a physician's order dated 6/28/21, directed R10 to receive a consistent carbohydrate of International Dysphasia Diet Standardization Initiative (IDDSI) six textured diet (soft and bite sized food, low sodium diet for safety and comfort).

R10's care plan revision date 11/15/20, indicated R10 was to receive a consistent carbohydrate, low sodium diet. In addition, staff were directed to monitor intake and record all meals, and to support and encourage compliance with therapeutic diet restrictions. Although the care plan directed staff to monitor intake and record all meals, there was no evidence of any documentation although it was requested.

On 9/22/21, at 8:50 a.m. R10's meal ticket was observed to read "diabetic, soft bite size foods".

R16's Admission Record printed 9/27/21, indicated R16's diagnoses included type two diabetes, HTN, hyperlipidemia, and Alzheimer's disease.

R16's Order Summary Report dated 9/27/21, included dietary orders for consistent carbohydrate diet.

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R17's Admission Record printed 9/27/21, indicated R17's diagnoses included type two diabetes, stage three chronic kidney disease, and HTN.

R17's Order Summary Report dated 9/27/21, included dietary orders for consistent carbohydrate diet.

R18's Admission Record printed 9/27/21, indicated R18's diagnoses included type two diabetes, HTN, and Alzheimer's.

R18's Order Summary Report dated 9/27/21, included dietary orders for a consistent carbohydrate diet.

R19's Admission Record printed 9/27/21, indicated R19's diagnoses included congestive heart failure, type two diabetes, stage three chronic kidney disease, and HTN, hyperlipidemia and edema.

R19's Order Summary Report dated 9/27/21, included dietary orders for a consistent carbohydrate diet.

R22's Admission Record printed 9/27/21, indicated R22's diagnoses included type two diabetes, stage four chronic kidney disease, pulmonary hypertension, and congested heart failure.

R22's Order Summary Report dated 9/27/21,

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included dietary orders for a consistent carbohydrate, low sodium, low potassium diet.

R24's Admission Record printed 9/27/21, indicated R24's diagnoses included severe protein calorie malnutrition, adult failure to thrive, HTN, and anorexia.

R24's Order Summary Report dated 9/27/21, included dietary orders for NAS diet.

R27's Admission Record printed 9/24/21, indicated R27's diagnoses included moderate persistent asthma, pulmonary hypertension, depression, polymyalgia rheumatica (an inflammatory disorder causing muscle pain and stiffness), obstructive sleep apnea (intermittent airflow blockage during sleep), and muscle weakness.

R27's Order Summary Report dated 9/24/21, indicated a physician's order dated 1/25/21, directed R27 to receive a heart healthy diet.

R27's care plan initiated 9/29/20, directed staff to provide and serve diet as ordered. R27's diet was identified as heart healthy.

On 9/22/21, at 8:53 a.m. R27's meal ticket identified her diet as heart healthy and lactose free.

On 9/22/21, at 12:00 p.m. R27 was observed eating fried rice with chicken, she stated she was going to have some of the fried rice and shrimp as well, just "a taste". R27 had used regular soy sauce on her fried rice. The fried rice with shrimp

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or chicken was the only entree choice being served.

R28's Admission Record printed 9/27/21, indicated R28's diagnoses included HTN, localized edema, Alzheimer's, and dementia.

R28's Order Summary Report dated 9/27/21, included dietary orders for a two gm sodium diet.

R29's Admission Record printed 9/27/21, indicated R29 diagnoses included type two diabetes, hypertensive heart disease, stage four chronic kidney disease, heart failure, and atrial fibrillation.

R29's Order Summary Report dated 9/27/21, included dietary orders for a renal diet (a diet that restricts sodium, phosphorus and potassium).

R30's Admission Record printed 9/27/21, indicated R30's diagnoses included stage three chronic kidney disease, type two diabetes, congestive heart failure, hyperlipidemia, HTN, and edema.

R30's Order Summary Report dated 9/27/21, included dietary orders for consistent carbohydrate diet.

R31's Admission Record printed 9/27/21, indicated R31's diagnoses included hypertensive heart disease, and TIA.

R31's Order Summary Report dated 9/27/21,

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included dietary orders for a heart healthy and lactose free diet.

R33's Admission Record printed 9/27/21, indicated R33's diagnoses included end stage renal disease (kidneys can no longer function on their own) , and type one diabetes.

R33's Order Summary Report dated 9/27/21, included dietary orders for a renal diet of regular textured foods, thin consistency, and renal consistent carbohydrate diet.

R34's Admission Record printed 9/27/21, indicated R34's diagnoses included type two diabetes, HTN, and hyperlipidemia.

R34's Order Summary Report dated 9/27/21, included dietary orders for a consistent carbohydrate diet.

R37's Admission Record printed 9/27/21, indicated R37's diagnoses included type two diabetes, atrial fibrillation (irregular, rapid heart rate), ischemic cardiomyopathy (weakened heart muscle), stage three kidney disease, and HTN.

R37's Order Summary Report dated 9/27/21, included dietary orders for a consistent carbohydrate, two gram (gm) low salt, and a low-fat diet.

R38's Admission Record printed 9/27/21, indicated R38's diagnoses included HTN, stage three chronic kidney disease, edema, congestive

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heart failure, and atrial fibrillation.

R38's Order Summary Report dated 9/27/21, included dietary orders for a heart healthy diet.

R46's Admission Record printed 9/27/21, indicated R46's diagnoses included congested heart failure, stage three chronic kidney disease, HTN, and dementia.

R46's Order Summary Report dated 9/27/21, included dietary orders for a heart healthy diet.

R47's Admission Record printed 9/27/21, indicated R47's diagnoses included type two diabetes, atrial fibrillation, HTN, hyperlipidemia, and dementia.

R47's Order Summary Report dated 9/27/21, included dietary orders for consistent carbohydrate diet.

On 9/21/21, at 11:46 a.m. R10 was served beef stroganoff, this was the same meal served to all the residents.

On 9/21/21, at 11:48 a.m. R27 was observed eating noodles with butter.

On 9/21/21, at 12:05 p.m. the assistant director of nursing (ADON) stated dietary had been historically responsible for tracking dietary intake.

On 9/22/21, at 7:14 a.m. during a kitchen tour, a white dry erase board was observed hanging on the wall in the kitchen which listed the following

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resident diets:
-30 regular diets with one puree and two nectar thickened liquids
-12 consistent carbohydrate diets with one bite size moist, one mechanical soft and one nectar thickened liquids
-3 heart healthy
-2 Renal
-1 vegetarian

On 9/22/21, at 9:05 a.m. cook (C)-A stated specialized diets like diabetic, heart healthy, low sodium were getting the same food as residents on regular diets. C-A stated she tried to give less portions to the specialized diets but did not measure for portion sizes. C-A stated she had two residents on renal diets, and they ate what was on the menu except for potatoes and bread. C-A stated the dietary staff were doing the best they could. C-A further stated the DM left abruptly and took all of the recipes and C-A was cooking from her experience cooking with her grandmother. C-A stated she had not had any communication with the dietician.

On 9/23/21, at 10:16 a.m. the administrator stated he was aware residents had concerns on the quality of meals, menus, diet orders and overall dining experience since March 2021. The administrator further stated the facility had not had a consistent dietary manager for several months, so the cooks were using canned food and boxed foods due to convenience and low dietary staff. The administrator acknowledged residents were not getting their special diets when using canned foods, or prepackaged foods. The administrator further stated he recently hired a dietary manager consultant from out of state who would be making some onsite visits educating

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and training dietary staff.

On 9/23/21, at 4:02 p.m. the dietary manager consultant (DMC)-A stated he was hired a couple of weeks ago because the facility did not have a dietary manager. The DMC-A stated it was his first visit to the facility and was able to assess the facility needed new menus, and the dietary staff required training and education on following menus, preparing homemade foods, portion sizes, and how to cook to a menu to make sure residents were being provided specialized diets. The DMC-C stated he planned being on site at the facility for a couple of days and then would re-evaluate what the facility needs were and develop a plan moving forward.

On 9/24/21, at 9:15 a.m. nursing assistant (NA)-C stated she was not sure if R10 was on a special diet.

On 9/24/21, at 9:43 a.m. nursing assistant (NA)-D stated she was not sure about any special diets for residents and was not recording intakes.

On 9/24/21, at 11:53 a.m. the registered dietician (RD)-D stated she had not reviewed or approved the facilities current menus. RD-D stated the facility has not had a consistent dietary manager in several months and the DM was the key to a properly managed kitchen. The RD-D stated historically, the facility did not have a lot of residents were on therapeutic diets and the current kitchen staff were not trained or educated on how to make appropriate substitutions or use portion control to meet the dietary needs of the residents. The RD-D stated she was unaware the cooks were not preparing meals from scratch and foods were being prepared from canned and

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prepackaged foods, which were "loaded" with sodium and carbohydrates. RD-D did not believe anyone in the facility was tracking any dietary intake for residents.

On 9/24/21, at 12:46 p.m. RN-A stated she did not know if any residents were on therapeutic diets. RN-A stated she was only aware of food allergies.

On 9/24/21, at 2:08 p.m. the administrator stated he was aware there were concerns with the cleanliness and organization of the kitchen, proper food handling, and food storage. The administrator further stated the current menu and preparation of foods did not meet prescribed therapeutic diets.

On 9/27/21, at 11:27 a.m. the director of nursing (DON) stated there had not been a consistent dietary manager for several months. The DON further stated he would expect residents to receive diets as ordered by their physician to meet the resident's dietary needs to manage acute and chronic health conditions. In addition, the DON would expect staff to follow the resident's care plan to track the resident's dietary intake.

The facility policy Diet Orders dated 2013, indicated the facility would provide a therapeutic diet that was individualized to meet the clinical needs and desires of the patient/resident to achieve outcomes/goals of care. The policy further indicated diets would coincide with the therapeutic diets on the facility menu. The policy directed the registered dietician (RD) would approve all therapeutic diets on the menus. The RD or designee would be notified of any

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F 808	Continued From page 68 therapeutic diets not listed on the menu, so that they can be developed as appropriate. The policy further indicated a therapeutic diet was a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered a nutritional status, to eliminate, decrease or increase certain substances on the diet (e.g., sodium, potassium).	F 808		
F 812 SS=F	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. (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 failed to ensure food temperatures were taken and recorded, leftover food was properly cooled and temperatures taken before stored in the cooler to prevent food borne illness.. In addition, the facility failed to ensure the kitchen	F 812	F812 1. All dietary staff will attend an in-person training session on November 1, 2021, that will entail safe food handling, infection prevention/ hand	11/4/21

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F 812	Continued From page 69 food prep areas, kitchen equipment, appliances, and clean dish storage areas were clean to prevent food borne illness and the garbage cans were closed to prevent cross-contamination. This had the potential to affect all 48 residents residing in the facility, who ate food from the kitchen. Findings include: FOOD TEMPERATURES On 9/22/21, at 7:39 a.m. cook (C)-A stated they started checking food temperatures in August 2021, and further stated food temperature logs were not being completed at each meal. On 9/22/21, at 11:25 a.m. C-A was observed checking food temperatures at the steam tables prior to serving. In between checking food temperatures, C-A did not sanitize the thermometer probe and wiped the temperature probe with a used dish towel that was on the counter. C-A did not check the temperatures of the fried rice or white rice and stated she knew the rice was cooked thoroughly because all of the water in the pan was absorbed. On 9/23/21, at 11:29 a.m. the dietary manager consultant (DMC)-A stated he reviewed all of the food temperature logs and verified food temperatures were not being completed as required, and further stated there were many days food temps were not recorded on the weekends. COOLING FOODS: On 9/22/21, at 12:34 p.m. C-A stated after she was done serving food, she would put the leftover food into a container, cover it, date it, and put it directly into the cooler. C-A stated she had not	F 812	hygiene, general kitchen sanitation, and food borne illnesses. This requires all dietary staff to demonstrate proper hand hygiene to the culinary operations consultant at the time of the in-service. Training record will be maintained in the dietary services office. " All observations and auditing tools will be initiated starting November 1, 2021. " Visual observation of staff performing food production and taking temperature readings appropriately before meal service, at the end of meal service, and when cooling leftovers before storing in the refrigerator will be completed daily and logged on the food temperature log, by the culinary operations consultant or dietary designee. These logs will be kept monthly in the dietary office. " Safe food handling will be done via food temperature log audits daily by dietary designee. " Daily temperature logs will be completed three times daily for the kitchen walk-in cooler and kitchen walk-in freezer via an internal thermometer and an external thermometer and will be audited daily by designated dietary staff member. " Hand hygiene audits will be completed daily per shift by designated dietary supervisor. The audits will be kept in the dietary office.	

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F 812	Continued From page 70 been checking food temperatures for cooling foods before putting the leftovers in the refrigerator, and had never heard of cooling food down before storing in the cooler. C-A was unable to provide left over food temperature logs for cooling left overs. On 9/23/21, at 11:29 a.m. the DMC-A stated he was unable to find any cooling temperatures for left over food. The DMC-A stated when cooling left over food properly, food temperatures should be completed to make sure the food was cooled to the ideal temperature before putting the food into the cooler to prevent food borne illness. On 9/23/21, at 4:02 p.m. a follow up interview was conducted with DMC-A. The DMC-A stated if cooked foods were not properly cooled, it had the risk of growing bacteria in the temperature danger zone which could cause severe illness. CLEANLINESS OF THE KITCHEN: During the initial kitchen tour on 9/20/21, at 12:00 pm with cook (C)-A: -The double sink located to the left of the rear entrance of the kitchen had a bin with individualized cereal containers sitting on the flat part of the metal sink, along with an opened box of bananas, various paperwork and miscellaneous office supplies, and a variety of clear storage containers. Ice cubes were in one of the sink compartments with 2 plastic white bins turned upside down over the sink compartments. -Garbage cans next to the steam tables and clean dishes were uncovered. -The sink next to the food prep station had a	F 812	2. Dietary staff will be trained on proper food storage, FIFO, and dating of food products for both the cooler and the freezer. This will include proper cleaning of kitchen food storage space as well. This training will be completed on November 1, 2021, by culinary operations consultant. " All kitchen food storage areas will be cleaned by dietary staff and inspected by culinary operations consultant. This includes kitchen cooler, kitchen freezer, dry storage space, and dietary hallway. This task will be completed by November 3, 2021. " All dietary staff will be trained on dish machine usage and monitoring of accurate temperatures and corrective actions. " All kitchen equipment will be cleaned by dietary staff and inspected by culinary operations consultant and placed on a routine cleaning schedule. 3. All policy and procedures pertaining to F 812 will be reviewed and revised as necessary by culinary operations consultant. All results will be reviewed at the monthly QAPI meeting.	

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large black tub drying upside down directly on the side of the metal sink along with wire racks, a gray bucket, metal serving pans, a clear plastic storage container, and a sauce pan placed upside down directly on top of large plastic bin.

-Throughout the kitchen floor there were areas of dried food/fluid spillage, and small particles of foods.

-Opened undated dry spices above the stove had film build up on the outside of the containers.

-Hood vents above the oven/stove were visibly dirty with brown particles and dust build up.

-The griddle and gas burners had burned food debrief and grease build up.

-A three tiered metal cart which stored the blender, puree machine, knife cutter, and hot pads had dried food splattered on top of the shelf, along with a white powered substance and crumbs of food. The blender base was dirty with splatters of food and dust build up and the Ultra Robot puree machine had brown dried spillage on the front and sides of the base.

-Large mixer appeared clean and was not covered.

-The metal storage shelving below the coffee maker with sliding doors where strainers and maroon round containers were kept had food crumbs and dried spillage of unknown substance on shelves.

On 9/20/21, at 1:12 p.m. the dietary aide (DA)-A stated they had been without a dietary manager

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for about a month and had been short staffed with one to two dietary aides in the kitchen. DA-A further stated C-A had been working double shifts every day because there was no dietary manager and the other cook was on vacation.

On 9/20/21, at1:19 p.m. C-A stated she had been in her position for about two months. C-A stated there was no cleaning schedule and verified deep cleaning was not being done, including cleaning small appliances, wiping shelving, floors, due to not having enough time and staff to complete cleaning task. C-A stated temperatures of the coolers and freezer were not being done daily. C-A verified there was a substantial amount of dust and grime build up on the hood vents located over the stove and oven and needed to be cleaned. C-A stated the kitchen should be staffed with three dietary aides, and they were usually staffed with one to two dietary aides. C-A further states she normally worked 11 a.m. to 7:00 p.m. but due to lack of dietary staff, C-A was working every day covering all shifts.

On 9/22/21 7:19 a.m. continuing the kitchen tour:
-The walk in freezer had a total of eight boxes frozen foods including chicken, Crustables, white turkey patties, tubes of hamburger stored on the bottom of the freezer.

-Small dishes of mandarin oranges were not dated and uncovered in the walk in cooler.

-An open block of butter was in a bowl on a shelf (covered) and undated next to stove.

-A towel was on the wood block counter top with two clear plastic tubs, a small cutting board, a measuring cup, and knives drying directly on the

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F 812	Continued From page 73 towel. -The outer surfaces of the metal cabinets, walk in cooler, refrigerators were dirty with multiple finger prints and smudges on the doors, dried drippings of food/fluid and food debris on the metal shortage shelves. -In the walk in cooler, all on the same wire rack, was an undated Ziploc plastic bag of cooked bacon, an opened, undated package of sliced ham, and an undated covered bowl of cottage cheese. On a three tiered shelf was an undated, opened packaged of cubed chicken next to a box of celery. -The outside of the sugar and flour metal bins and lids had a build up of flour residue and a blue cup with a handle in the flour bin. -A clear water pitcher was being dried upside down directly on the side of the two sided compartment sink near the prep station. On 9/22/21, at 9:42 a.m. DA-A was observed putting dirty dishes through the dishwasher and carts were observed with dirty dishes going past and stored next to uncovered clean racks of cups and plates. DA-A stated she ran the first wash cycle twice to make sure the water temperature had time to heat up. DA-A stated they were not testing the internal temperatures of the dishwasher and only relined on the outside temperature gauze. DA-A stated they use to have strips that they would put through the dishwasher that would change color to validate the internal temperature was hot enough for sanitization of the dishes	F 812		

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On 9/22/21, at 9:05 a.m. C-A verified food was not being stored correctly in the cooler but there was not enough staff in the kitchen, time, or space in the walk in cooler to organize food properly. C-A stated she was aware food should not be stored on the freezer floor and stated there was not enough shelving space to properly store the frozen foods.

On 9/22/21, at 9:52 AM DA-B stated the did not have a cleaning schedule and stated we "clean as we go." DA-B further stated there was not time to deep clean or wipe down shelving, clean the outside of the metal cabinets or cooler because they were short staffed in the kitchen, DA-B verified the small appliances were soiled with dried food spillage, food debris and dust build up. DA-A further verified the metal storage shelves for storing clean dishes had food crumbs and splattered food and/or fluid substance on the shelves, and the floors were needed to be swept and mopped.

On 9/22/21, at 11:13 a.m. the environmental director (ED)-A stated the kitchen hood and vent was last cleaned on 6/2/21, by Northland Fire and Safety and was aware it was over due for cleaning . ED-A verified the kitchen stove/oven hood vents needed to be clean and were full of dust and grease build up. The ED-A stated the stove and oven were not on the quarterly cleaning schedule, and he relied on the cooks to let him know when the stove and oven needed cleaning. The ED-A stated maintenance tried to the kitchen staff by cleaning the walls and floors but it had been a challenging keeping up cleaning the kitchen due to not having enough staff.

During kitchen observations on 9/22/21, at 11:25

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F 812	Continued From page 75	F 812		

a.m.
-The outside of the sugar and flour metal bins and lids had a build up of flour residue and a blue cup with a handle was in the flour bin.
-A clear water pitcher was being dried upside down directly on the side of the two sided compartment sink near the prep station.

On 9/23/21, at 10:16 a.m. the administrator stated they started using canned foods after the dietary manager left and not having enough dietary staff to help in the kitchen. The administrator further stated he was aware residents were not getting special diets when using canned and pre-packed foods. The administrator stated he talked to the consultant when the dietary manager left, but he had not been in there yet. The administrator stated he was aware they have problems in the kitchen and are working on them.

On 9/23/21, at 11:29 a.m. the DMC-A stated he was contacted a couple of weeks ago to help out in the kitchen because the facility was without a dietary manager. The DMC-A stated he had not been in contact with the facilities dietician or the cook at that time and this was his first on site visit. The DMC-C stated he took a brief walk through the kitchen and saw the kitchen was in bad shape and needed immediate interventions. The DMC-A stated food should not be stored on the floor to prevent possible contamination and clean dishes should not be stored in the same area of dirty dishes, and clean wet dishes should be dried on racks allowing air to circulate and not a towel.

On 9/23/21, at 4:02 p.m. a follow up interview was conducted with DMC-A. DMC-A stated he

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was working on cleaning the food prep station, and overall cleaning and de-cluttering the kitchen. DMC-A further stated cleaning in the kitchen was overdue and verified the small appliances, floors, oven vents, walk in cooler, prep stations, counters, and shelves were unclean. DMC-A verified cleaning logs were not being kept, food temperatures were not being logged daily and fridge and freezer temps were not consistently logged. The DMC-A stated after dinner the coolers were going to be cleaned out and all the left overs thrown out since cooked foods were not cooled properly before storing in the coolers. The DMC-A stated if cooked foods were not properly cooled, it had the risk of growing bacteria in the temperature danger zone which could cause severe illness. The DMC-A stated the kitchen staff had been without consistent leadership and staff needed a lot of education and training on proper food storage, safe food and dishware handling.

On 9/24/21, at 2:08 p.m. the administrator stated he was aware there were concerns with the cleanliness and organization of the kitchen, proper food handling, and food storage.

The facility policy Food Temperatures dated 2013, indicated the temperatures of the food would be taken and properly recorded each meal.

The facility policy Food Storage dated 2013, directed the following:
-Scoops for bulk foods were not to be stored in the food containers and kept covered in a protected area near the containers.
-Food items will be stored on the shelves.
-Food should be stored a minimum of six inches above the floor.

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-Leftover food was stored in containers or wrapped securely, clearly labeled, dated and used within three days or discarded.
-Every refrigerator must be equipped with an internal thermometer.

The facility policy Use of Leftovers dated 2013, directed the following:
-Leftovers will be covered, labeled and dated.
-Leftovers must be cooled to 70 degrees F within two hours and then down to 41 degrees F within another four hours.
-Leftovers that have not been properly stored will be discarded

The facility policy General Sanitation of Kitchen dated 2013, directed the following:
-Cleaning and sanitation tasks for the kitchen were to be recorded.
-Frequency for cleaning for each task would be defined.
-A cleaning schedule would be posted.

The facility policy Cleaning Dishes/Dish Machine dated 2013, directed the following:
-Allow dishes to air dry on the dish rack, Do not dry with towels.
-Flatware should be presoaked prior to washing and washed twice.
-Thermal strips may be use as verification that the temperature is adequately hot.

The facility policy Food Temperatures dated 2013, indicated the temperatures of the food would be taken and properly recorded each meal.

The facility policy Resource: Taking Accurate Temperatures darted 2013, indicated thermometers should be sanitized according to

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F 812	Continued From page 78 the manufacturer's instructions and further directed to use an alcohol swab in between uses. The facility policy Cleaning Instructions: Food Preparation Appliances dated 2013, indicated small appliances (such as mixers and food processors) would be cleaned and sanitized after each use. The facility policy Cleaning Instructions: Cabinets and Drawers dated 2013, indicated cabinets and drawers would be free from food particles and dirt and should be clean at least twice a month. Cabinets and drawers were cleaned as needed when spills occurred. The facility policy Cleaning Instructions: Hoods and Filters dated 2013, indicated stove hoods and filters would be cleaned according to the cleaning schedule, or at least monthly.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		11/4/21

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reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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F 880	Continued From page 80 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: Bushey, Sativa Based on observation, interview, and document review, the facility failed to ensure unclean gloves were changed and utensils used to handle food during food service to prevent cross-contamination. This had the potential to effect all 48 residents who ate food from the kitchen. In addition, the facility failed to ensure hand hygiene was performed between serving residents in the dining room. Findings include: HAND HYGIENE RELATED TO GLOVES, FOOD HANDLING AND ENVIRONMENTAL TOUCH On 9/20/21, at 4:18 p.m. during continuous observation of dining: unclear if these sandwiches are wrapped or not. -at 4:49 p.m. the facility's business office manager (OM)-A left the steam table, picked up a dish towel, wiped down the metal steam table, put the scraps of food into the garbage, removed gloves, and put on a new pair of gloves. OM-A picked up a dirty plate from the kitchen, put it in the dirty sink then returned to the serving station and dished up a Reuben sandwich and fries wearing the same pair of gloves.	F 880	F880 Directed Plan of Correction A root cause analysis was conducted by the QAPI committee and reviewed with the Medical Director and Governing Body President addressing the cited hand hygiene practice. The DON(Infection Preventionist) and the ADON(Clinical Education Coordinator) reviewed our hand hygiene policies and procedures to ensure that they meet the CDC guidance and CMS requirement. They developed and implemented a competency assessment for staff on proper hand hygiene and have developed a system to ensure all staff have received the training and are competent. A hand hygiene looping video is placed at the time clock for all staff to view as they report/leave to/from work. A power point was developed to present to staff on hand hygiene. The DON, ADON and facility leadership are conducting hand hygiene audits every day X 7 days, every shift. Completion of this auditing period will be on 10/28/21. The audits will be reviewed	

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F 880	Continued From page 81 - at 4:54 p.m. without using tongs or utensils, OM-A handled the Reuben sandwiches with gloved hands and placed the sandwiches on the plates. OM-A would go back an forth handling the sandwiches with gloved hands and handling the utensils scooping up french fries. -at 4:58 p.m. OM-A reached in a bin of pre-made wrapped meat sandwiches, wearing the same pair of gloves, picked up a Reuben sandwich with gloved hand and placed the sandwich on a plate with fries. -at 5:03 p.m. OM-A came out of the kitchen wearing the same gloves, touched a couple of food trays inside the room cart, went back into the kitchen, grabbed a Reuben sandwich with the same gloved hands and put the sandwich on a plate with fries. -at 5:06 p.m. OM-A came out of the kitchen, arranged room trays in the room carts, and wearing same gloves went back into the kitchen and rested gloved hands directly on the serving counter. -at 5:12 p.m. OM-A came out of the kitchen with the same gloved hands, grabbed a tray from the room cart and put a dessert on the tray. OM-A then took the tray with pudding cups, brought it into the kitchen and placed the tray of puddings into the walk in cooler. -at 5:19 p.m. wearing the same pair of gloves, OM-A left the steam table, grabbed a box of plastic wrap and wrapped a plate with wrap. OM-A proceeded to handle three Reuben sandwiches with gloved hands, cut the Reuben	F 880	at the quarterly QAPI meeting held on 10/28/2021. Audit documentation/education will be uploaded to DPOC when completed. All residents have the potential to be affected by this practice. The facility will continue to educate staff on proper hand washing/sanitation procedures during the 90-day auditing period. Results will be reviewed at the monthly QAPI meetings. The Director of Nursing, ADON, or designee will audit 10 employees for handwashing/sanitation per week x 30 days, 5 employees for handwashing/sanitation per week x 30 days, and 3 employees for handwashing/sanitation per week x 30 days, for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period. F880 1. All residents receiving meals in the facility have the potential to be affected by the alleged deficient practice. 2. All dietary staff will attend an in-person training session on November 1, 2021,) that will entail safe food handling, infection prevention, hand hygiene, general kitchen sanitation, and food borne illnesses. This requires all dietary staff to demonstrate proper hand hygiene and proper donning and doffing gloves to the	

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F 880	Continued From page 82 sandwiches in half and placed the sandwiches on the plate. OM-A left the steam table, went to the microwave and heated up a bowl of soup, then handed the bowl of soup to staff serving the residents in the dining room. OM-A proceeded to walk in the cooler, grabbed a chef salad then went to the dry goods storage room, grabbed salad dressing, removed the saran wrap from salad plate, placed the salad dressing on a plate, then re-wrapped the salad plate. OM-A then picked up a Reuben sandwich with the same gloved hands, cut the sandwich in half them placed the cut sandwiches on the plate with fries. OM-A picked up a used piece of saran wrap and foil that was on the counter and tossed it in the garbage. OM-A touched her surgical mask with gloved hands, then rested gloved hands on the serving counter. Without changing gloves or performing hand hygiene, OM-A picked up three more plates and placed Reuben sandwiches and fries on each plate. -at 5:31 p.m. OM-A touched her mask with her gloved hand, grabbed a plate of food and placed the food on a room tray then went back into the kitchen. Wearing the same pair of gloves, OM-A touched the Reuben sandwich with her gloved hands, cut the sandwich in half then placed the sandwich on the plate with fries. On 9/20/21, at 5:36 p.m. OM-A stated she had been helping serve food in the kitchen for the past couple of weeks because the kitchen was short staffed. OM-A verified she had not performed hand hygiene in between glove changes or change gloves when she left the steam tables and touched other items in the kitchen. OM-A stated she did not realize she touched her surgical mask with her gloved hands	F 880	culinary operations consultant at the time of the in-service. Training record will be maintained in the dietary services office. " All observations and auditing tools will be initiated November 2, 2021. " Hand hygiene audits will be completed daily per shift by designated dietary supervisor. The audits will be kept in the dietary office. 3. All policy and procedures pertaining to F 880 will be reviewed and revised as necessary by culinary operations consultant.	

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and continued to serve food. OM-A stated she was not trained in the kitchen and usually worked in the office.

During dining observation on 9/22/21, at 7:51 a.m. dietary aide (DA)-A walked in the kitchen from the dining room, dished up a bowl of oatmeal, added brown sugar and delivered to a resident in the dining room. DA-A did not perform hand hygiene before dishing up the oatmeal. DA-A was interviewed and stated said she did not touch anything so did not think performing hand hygiene was necessary before she dished up a bowl of oatmeal.

HAND HYGIENE BETWEEN SERVING RESIDENTS
On 9/20/21, at 4:20 p.m. there were 16 tables in the dining room with one to four residents per table.

On 9/20/21, at 4:33 p.m. a continuous observation of activities staff (A)-A was begun and concluded at 5:11 p.m. A-A was observed coming out of the kitchen wearing gloves and a hairnet. A-A kept her gloves on, touched her hair and hairnet, and walked over to a cart. A-A then touched her hairnet again with gloved hands, walked to table 11 pushing the cart. A-A seated herself at the table and asked the residents what they wanted to eat; she stood using the arms of the chair to stand up. A-A stopped to talk with residents, touching the arms of chairs and returned with the cart to the kitchen window. She was not observed changing her gloves or using hand sanitizer.

On 9/20/21, at 4:43 p.m. A-A served the residents at table 11, kept her gloves on and went to table

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10 and took meal orders.

On 9/20/21, at 4:46 p.m. A-A, still wearing the same gloves, picked up new entrees to serve to residents at table 10.

On 9/20/21, at 5:00 p.m. A-A removed her gloves and put them on the second shelf of the cart. She was not observed washing her hands or using hand sanitizer.

On 9/20/21, at 5:11 p.m. A-A stated she helped serve food maybe two times a week. A-A verified she kept the same gloves on during the meal service but stated she used hand sanitizer over her gloves prior to picking up a new plate of food. Although A-A stated she used hand sanitizer over her gloves, this was not observed during the continuous observation.

On 9/24/21, at 10:25 a.m. the director of nursing (DON) and the assistant director of nursing (ADON) verified staff cannot wear the same gloves throughout the dining service to serve multiple residents, they need to perform hand hygiene if they touch their hair. Both verified it was not acceptable practice to use hand sanitizer to clean gloves between serving residents.

The facility policy titled Handwashing/Hand Hygiene undated, directed staff to perform hand hygiene after removing gloves, before and after assisting a resident with meals. The policy further directed "the use of gloves does not replace hand washing/hand hygiene."

The facility policy titled Food Preparation and Service undated, directed staff to wash their hands prior to serving food to residents. The

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F 880	Continued From page 85 policy also directed staff that disposable gloves were single-use items and are discarded after each use.	F 880		
F 943 SS=F	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all staff received annual abuse prevention and vulnerable adult (VA) training. This had to potential to affect all 48 residents. Findings include: A review of the undated facility Abuse Policy and Procedure revealed the policy lacked direction for staff to receive annual abuse prevention and vulnerable adult training. A review of the staff education completion of	F 943	The abuse policy was updated by the facility□s NHA during the survey to include that training of Abuse, Neglect, and Exploitation would be completed annually. All residents have the potential to be affected by this practice. The facility will ensure that all employees have completed annual of Abuse, Neglect, and Exploitation training no later than 11/04/21. Annual abuse training will be assigned to be completed in a specific	11/4/21

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F 943	Continued From page 86 Abuse/VA training, revealed nursing assistant (NA)-D with a start date of 3/26/20, and licensed practical nurse (LPN)-C with a start dated of 2/20/19, had not completed annual abuse/VA training within the past year. On 9/23/21, at 10:16 a.m. the administrator verified the facility policy for abuse lacked direction for staff to receive abuse prevention and vulnerable adult training during orientation and annually, and stated staff should receive abuse/VA training at orientation and annually.	F 943	month of the year. The Director of Nursing, ADON, or designee will audit 5 employees for verification of Abuse, Neglect, and Exploitation training and knowledge per week x 30 days, 3 employees per week x 30 days, and 2 employees per week x 30 days for a total of 90 days. Results of the Audits will be reported at the monthly QAPI meetings for the 90-day period for a total of 90 days.	

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AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Aftenro Home 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care, and the 2012 edition of the Health Care Facilities Code (NFPA 99). 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

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

Electronically Signed | 10/29/2021

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. The facility was surveyed as one building. Aftenro Home is a 3-story building with no basement. The building was constructed at 4 different times. The original 3 story building was constructed in 1921 and was determined to be of Type II(222) construction. In 1935, a 3 story addition was constructed to the North that was determined to be of Type II(222) construction. In	K 000		

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K 000	Continued From page 2 1990, a 2 story addition was constructed to the East that was determined to be of Type II(222) construction. In 2001, a 1 story addition was constructed above the 1990 East addition that was determined to be of Type II(222) construction. Because the original building and the 3 additions are of the same type of construction. This building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 53 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide unobstructed access to the means of egress as required by the Life Safety Code (NFPA 101) 2012 edition section	K 211	K211 All residents are effected by this practice.	11/4/21

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K 211	Continued From page 3 19.2.2 & 7.1.10.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/23/2021, at 12:30 PM, observations revealed the chairs and a couch obstructing that are located in the means of egress on the 3rd floor east wing by the nurse's station are reducing and blocking the corridor and egress access. This deficient condition was verified by a Maintenance Supervisor.	K 211	The couch and chair that was was obstructing the means of egress on the 3rd floor east wing has been removed. All means of egress have been inspected by the maintenance director for compliance. The maintenance director/designee will conduct weekly audits of all means of egress x 3 months to ensure compliance. The maintenance director will report to the QAPI committee findings of the audits.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm in accordance with NFPA 101 "Life Safety Code" 2012 edition, section 9.6.1.3, and NFPA 72 "National Fire Alarm and Signaling Code" 2010 edition, sections 14.5.3. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility.	K 345	K345 This practice could have an impact on all of the residents. The maintenance director has scheduled ESC, the fire alarm vendor to test the fire alarm system on November 2, 2021. This semiannual inspection has been added to	11/4/21

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K 345	Continued From page 4 Findings include: On 09/23/2021, at 11:45 AM, during a review of all available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. This deficient condition was verified by a Maintenance Supervisor.	K 345	the preventive maintenance schedule to ensure future compliance. The administrator has a copy of the preventive maintenance schedule to assist with monitoring of the schedule and scheduling the vendor for compliance as required by the life safety code. The administrator and maintenance director are responsible for ensuring compliance. All results will be discussed at the QAPI meeting.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		11/4/21

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K 353	Continued From page 5 by: Based on staff interview and a review of the available fire sprinkler test and inspection documentation, the automatic sprinkler system is not maintained in accordance with NFPA 25 "Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems" 2011 edition, section 5.2.5 and 5.3.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/23/2021, at 12:52 PM, the gauge that is on the sprinkler system main riser was marked as being replaced on 06/2016 and is outside of the 5 year gauge replacement or re-calibration time frame. This deficient condition was verified by a Maintenance Supervisor.	K 353	K353 This practice could have an impact on all of the residents residing at Aftenro. The maintenance director ordered the gauges on 10/25 and they will be replaced on receipt. This task will be added to the preventive maintenance schedule. A tag clearly marked with the expiration date will be hung on the system. The sprinkler system has a visual weekly inspection. On the preventive maintenance schedule a line will be added to indicate the expiration date. The maintenance director are responsible for monitoring compliance. The maintenance director will report to the QAPI committee the completion of the installation of the gauges and this plan of correction.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller	K 363		11/4/21

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K 363	Continued From page 6 latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility had 1 of multiple corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition, section 19.3.6.3. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/23/2021, at 12:45 PM, observation	K 363	K363 This practice could have an impact on all residents residing at Aftenro. The cited doors have been replaced by solid wood latching doors. The maintenance director is responsible for the compliance of all doors in the building .	

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K 363	Continued From page 7 revealed that the linen storage closet B3 was open to the corridor and equipped with bi-fold doors. The doors to the linen closets were bi-fold doors that were not automatically positively latching and there was a 3/4" gap between the bi-fold doors where the came together. The doors were not constructed to limit the transfer of smoke and do not meet the requirements for corridor doors. This deficient condition was verified by a Maintenance Supervisor.	K 363	The maintenance director will report to the QAPI this plan of correction.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. This deficient condition could have a widespread impact on the residents within the facility.	K 712	K712 This practice could affect all residents residing at Aftenro. The maintenance director will resume a schedule that will reach all three shift each quarter for fire drills. In addition, drills will	11/4/21

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K 712	Continued From page 8 Findings include: 1. On 09/23/2021, at 11:30 AM, during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct a fire drill for the overnight shift in the 3rd calendar quarter. 2. On 09/23/2021, at 11:30 AM, during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not vary the times of the 3rd shift fire drills by conducting 3 of 4 drills in the 11 PM hour. These deficient conditions were verified by the Maintenance Supervisor.	K 712	be conducted at differing times so that there is not a pattern established. The administrator/designee will monitor the fire drill log for compliance monthly x 6 months or until compliance is achieved. All results will be reported to the QAPI committee.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99	K 901	K901 The facility utility risk assessment was located by the current administrator. It has also been updated. The maintenance	11/4/21

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K 901	Continued From page 9 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/23/2021 at 11:40 AM, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 901	director is responsible for the updating the assessment documentation as necessary and at least annually. Results will be reported at the next QAPI meeting.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general 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	K 914		11/4/21

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K 914	Continued From page 10 electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available electrical outlet maintenance and testing documentation, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 "Health Care Facilities Code" 2012 edition, section 6.3.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/23/2021, at 11:57 AM, during the review of all available electrical outlet maintenance and testing documentation and an interview with the Maintenance Supervisor, the facility could not provide any current documentation for the completion of the annual inspection and testing of the electrical outlets within patient/resident care areas located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 914	K914 This practice could have an impact on all residents of Aftenro. All electrical outlets have been inspected by the maintenance team. This inspection has been documented on the inspection form. The maintenance director has added this task to his preventive maintenance schedule. The administrator/designee is responsible for the monitoring the completion of this task. The administrator has a copy of the preventive maintenance schedule and will verify that the task is completed at the time. Results will be reported to the QAPI Committee at the meetings.	
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	K 920		11/4/21

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K 920	Continued From page 11 (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 interview with the staff the facility had a deficient conditions affecting the facility's electrical system that was not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, section 9.1.2, the NFPA 70 "National Electrical Code" 2011 edition, and the NFPA 99 " Healthcare Facilities Code" 2012 edition, section 10.2.4. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/23/2021, at 12:40 PM, during the facility tour, observations revealed that there is a small refrigerator that is plugged into a power strip that is plugged into a multi-plug adapter in resident	K 920	K920 This practice could have an impact on some residents. The maintenance team has inspected all rooms and areas for the use of extension cords and power strips. The power strip in room 252 has been removed and the refrigerator plugged into the wall. The maintenance director/designee is responsible for monitoring. Weekly audits will be conducted X three months The maintenance director will report the results to the QAPI committee.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 12 room 252. This deficient condition was verified by a Maintenance Supervisor.	K 920		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or 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	K 923		11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E355	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AFTENRO HOME	**510 WEST COLLEGE STREET** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 13 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 observations and staff interview, it was reveled that oxygen cylinders are not being stored in accordance with NFPA 99 "Health Care Facilities Code" 2012 edition, sections 11.6.5.2 and 11.6.5.3. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/23/2021 at 12:42 PM, during the facility tour observations revealed in the oxygen storage room located on the 3rd floor had oxygen cylinders that were not separated by full and empty at the time of the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 923	K923 This practice has the potential to affect some residents. The oxygen storage room has been clearly defined for staff delineating full and empty. A full cylinder and an empty cylinder area has been taped on off on the floor marking each and a full sign and and empty sign has been posted. The director of nursing is responsible for maintaining compliance. The DON/designee will conduct audits of the O2 room weekly x 90 days to ensure compliance. The director of nursing will report the results of the compliance to the QAPI committee.	