DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 5, 2022

Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: March 4, 2022

Dear Administrator:

On March 16, 2022, we informed you of imposed enforcement remedies.

On March 17, 2022, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 31, 2022, will remain in effect.

This Department continues to recommend 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 March 31, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 31, 2022.

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

As we notified you in our letter of March 16, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 31, 2022.

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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900

Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 4, 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

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

receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ 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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CHATEAU HEALTH CARE CENTER	**2319 WEST SEVENTH STREET SAINT PAUL, MN 55116**

(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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on On 3/14/22 through 3/17/22, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 3/14/22 through 3/17/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5028141C (MN00081648) H5028142C (MN00081683, MN00080695) H5028143C (MN00081517) H5028144C (MN00080148) H5028145C (MN00080208) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554	Resident Self-Admin Meds-Clinically Approp	F 554		4/12/22

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

Electronically Signed | 04/07/2022

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F 554 SS=D	Continued From page 1 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 interview and document review, the facility failed to conduct a self-administration of medication assessment for 2 of 2 residents (R21, R15) whom self-administered medications. Findings include: R21's admission Minimum Data Set (MDS) dated 1/22/22, indicated R21 was cognitively intact and had diagnoses of diabetes, cellulitis, and weakness. A physician order dated 2/1/22, indicated R21 was "ok to self-administer insulin." Review of R21's March 2022 Medication Administration Record (MAR) included: - Insulin Glangine inject 20 units (u) subcutaneously at bedtime. - Melatonin tablet. Give 3 milligrams (mg) one time a day for sleep. The medication was to be administered at bedtime. - NovoLog FlexPen 100u / milliliter (mL). Inject 7 units subcutaneously with meals. R21's medical record lacked evidence the facility completed an assessment which indicated R21 was able to safely self-administer medications. During an observation on 3/14/22, at 12:31 p.m. one pill was observed on R21's nightstand. R21	F 554	Immediate corrective action: Self-administration assessments were completed and reviewed by the IDT for R21 and R15. Corrective Action as it Applies to Others: Residents with physician orders to self-administer medications, or those who wish to SAM will be reviewed to ensure they have been assessed to do so safely. SAM assessments will be completed, as needed, for residents that have not already been assessed. Prevent Recurrence: The policy and procedure for self-administration of medications was reviewed and remains current. Licensed nursing staff will be educated on the policy for self-administration of medications. Ongoing Monitoring: 5 random weekly audits will be completed to ensure residents with physician orders to self-administer medications have been assessed, and IDT reviewed per facility policy. A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for further recommendations.	

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F 554	Continued From page 2 stated the pill was melatonin. R21 stated he did not want to take melatonin so early, so he had previously removed it from a medication cup and left it for later and forgot to take the medication. During an interview on 3/16/22, at 10:20 a.m. licensed practical nurse (LPN)-A verified there was a pill on R21's nightstand. LPN-A stated R21 administered his own medications including insulin. Orders were placed, but LPN-A was unaware if a self-administration of medication assessment had been completed for R21. Additionally, R21 stated staff had not discussed how to self-administer insulin or check his blood glucose, however, he had been doing this most of his life and did not need teaching. During an interview on 3/17/22, at 9:20 a.m. the director of nursing (DON) stated R21 had a medication self-administration assessment started on 1/31/22, but the assessment was not completed. The DON stated nurses were expected to ensure R21 was taking his medications and should not be self-administering without an assessment. During an interview on 3/17/22, at 5:37 p.m. nurse practitioner (NP)-LL stated R21 had an order to self-administer insulin as R21 was independent, however, a facility assessment was needed to ensure self-administered medications were taken correctly. Facility policy titled Self Administration of Medications revised 5/20, directed a self-administration assessment if a resident requested to self-administer medications. The completed assessment would be reviewed by the interdisciplinary team to determine	F 554	Completed By: Don/Designee	

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F 554	Continued From page 3	F 554		

appropriateness.

Review of R15's electronic medical record (EMR) undated "Admission Record," located under the "Profile" tab, indicated R15 had a diagnosis of Type 2 diabetes mellitus.

Review of R15's quarterly "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" 1/12/22 indicated R15 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R15 was cognitively intact.

Review of R15's "Clinical Physician Orders," located under the "Orders" tab indicated the physician ordered on 11/2/21, for R15 to be permitted to self-administer her insulin while at the bedside, while the resident was away from the facility, and in the community. On 11/2/21 the physician ordered NovoLog Flex Pen Solution Pen Injector 100/units/mL (milliliter) sliding scale to be administered subcutaneously before meals. On 11/2/21 the physician ordered Lantus Solo Star Solution Pen-Injector 100 unit/ml 42 units to be administered subcutaneously at bedtime.

Review of R15's medical record failed to indicate a self-administration of medication assessment was completed.

During an interview on 3/14/22 at 1:10 p.m., R15 stated she completed her own blood glucose checks and administered her own insulin. R15 showed her two insulin pens in a container during this interview.

During an interview on 3/17/22 at 5:00 p.m., the director of nursing (DON) stated she thought

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F 554	Continued From page 4 having a physician order for the self-administration of medication was enough During an interview on 3/17/22 at 5:23 p.m., nurse practitioner (NP)-LL revealed it was not appropriate for a physician order to determine if it was appropriate for R15 to self-administer insulin. The NP stated the facility should complete an assessment for the safe self-administration of insulin for R15. Review of a policy, "Self-Administration of Medication," dated May 2020, indicated "... An individual resident may self-administer medication if the resident requests and the interdisciplinary team has determined that self-administration is clinically appropriate. . .Explain procedure to the resident...Complete self-administration of medication assessment. . .If the team determines that self-administration is clinically appropriate, obtain a physician's order for resident to self-administer each specific medication that has been qualified to self-administer. . .The resident's care plan is revised to enable the resident to self-administer the specific medications. . .The self-administration of medications is reviewed quarterly by the interdisciplinary team..."	F 554		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident who	F 677	F677 Care for Dependent Residents (D) Immediate corrective action:	4/12/22

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F 677	Continued From page 5 is unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene for 1 of 1 resident who expressed concern regarding bathing. Findings include: Review R12's electronic medical record (EMR) under the Medical Diagnosis Tab revealed his diagnoses included quadriplegia (paralysis of all four limbs), muscle weakness, and contracture of the joints. Review of R12's (ADLs) "Plan of Care" located under the "Care Plan" tab of the EMR with a created and revision date of 1/5/22 revealed R12 had an ADL self-care deficit due to activity intolerance, hemiplegia, limited mobility, and limited range of motion. The interventions in the plan of care included requiring the assistance of one staff for bathing; being dependent on staff for dressing, eating, grooming, and mobility; and requiring the assistance of two staff for bed mobility and incontinence care. The interventions in the care plan also revealed R12 required full body lift and two staff members for transfers. The "Plan of Care" lacked indication of how often he was supposed to get a bath or a shower, however the "Tasks" tab in the EMR revealed the nursing assistant was supposed to give the resident a bath two times a week and as needed. The EMR was reviewed in its entirety and the only bath documented since his admission in January 2022 was on 03/11/22. On 3/14/22, at 2:32 p.m. R12 was interviewed in his room. During the interview the resident was	F 677	R12 was offered a bath. Corrective Action as it Applies to Others: Other dependent residents will be interviewed, and individual resident care plans will be updated to reflect personal bathing preferences. Dependent residents will receive bathing assistance per care planned interventions and bathing tasks will be documented in the electronic medical record. Prevent Recurrence: The policy for ADL cares was reviewed and remains current Nursing staff will be educated on the policy. Ongoing Monitoring: 5 random weekly audits will be completed to ensure bathing is completed and documented per patient preference in accordance with care planned interventions. A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for further recommendations. Monitored By: DON/Designee	

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F 677	Continued From page 6 asked if he received the help, he needed to get a bath. He stated that he was admitted two and half months ago and he had not received a bath or shower until last weekend. He stated he was told he would get a bath once a week, however, that did not happen. He stated he would like to get a shower twice a week. R12 stated the staff tell him they do not have enough staff to give him a bath when he asks. During an interview on 3/17/22, at 8:29 a.m. the director of nursing (DON) stated she was unable to find any documentation related to the R12 receiving baths. During an interview on 3/17/22, at 9:08 a.m. with nursing assistant (NA)-K revealed baths were documented in the EMR by the aide on the days they were given. He stated if no baths are documented then that indicated the resident did not receive one. He checked a book behind the nursing station and stated R12 was scheduled to receive his bath on Saturdays. He stated they were always short of staff on the weekends and most the time the resident did not get baths on weekends.	F 677		
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.	F 684		4/12/22

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F 684	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review, the facility failed to ensure 1 of 1 resident (R12) was transferred out of bed per physician order and per resident request. Findings include: Review of EMR under the "Medical Diagnosis" tab revealed R12 had diagnoses of quadriplegia (paralysis of all four limbs), cerebral palsy, muscle weakness, and contracture of the joints. Review of R12's Activities of Daily Living (ADLs) "Plan of Care" located under the "Care Plan" tab of the EMR with a created and revision date of 1/5/22, revealed R12 had an ADL self-care deficit due to activity intolerance, hemiplegia, limited mobility, and limited range of motion. The interventions in the plan of care included requiring the assistance of one staff for bathing; being dependent on staff for dressing, eating, grooming, and mobility; and requiring the assistance of two staff for bed mobility and incontinence care. The interventions in the "Care Plan" also revealed R12 required full body lift and two staff members for transfers, and he has an "electronic wheelchair that will be used upon arrival." Review of R12's "Physician's Orders" under the "Orders" tab in the EMR revealed on 1/26/22 the physician wrote an order to, "Ensure resident is up in w/c [wheelchair]every AM [morning]." Observations of R12 were completed on 3/14/22, from 12:15 p.m. through 7:07 p.m.; on 3/15/22, from 8:41 a.m. through 2:00 p.m.; on 3/16/22,	F 684	F684 Quality of Care (D) Immediate corrective action: Resident received assistance to transfer out of bed. Corrective Action as it Applies to Others: Other residents who require the assistance of 2 staff and mechanical lift for transferring out of bed will be reviewed to ensure they receive the assistance needed, according to physician orders, care planned interventions, or resident preference. Staff will document completion of the task in the resident□s EMR once completed. Prevent Recurrence: The policy for ADL care was reviewed and remains current. Nursing staff will be educated on the policy. Ongoing Monitoring: 5 weekly audits will be conducted to ensure residents who require transferring assistance receive the assistance necessary to transfer out of bed according to resident preference. A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for further recommendations. Monitored By: DON/Designee	

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from 5:24 a.m. through 3:30 p.m.; and on 3/17/22 from 9:01 a.m. through 1:01 p.m. On 3/16/22, at 1:30 p.m. and on 3/17/22, at 9:01 a.m. and on 1:01 p.m. the resident was asked if anyone had offered to get him up and he stated no. When asked if he would get up if they offered, he stated yes and each time he stated he had a doctor's order to get up.

Interview on 3/14/22, at 2:32 p.m. with R12 revealed the resident was in bed and stated staff was supposed to get him up and put him in his chair every morning. He revealed he was supposed be up five to six hours a day, but they never get him up. He stated every time he asked to get up the staff told him they do not have enough staff to get him up. He stated he was upset about not being assisted with getting up and even had a doctor's order to be gotten up in his chair every morning.

Interview on 3/17/22, at 9:00 a.m. the director of nursing (DON) confirmed R12 was supposed to be up in his chair every day.

Interview on 3/17/22, at 9:08 a.m. nursing assistant-(NA) K verified R12 remained in bed during his 6:00 a.m. to 2:00 p.m. shift and remained in bed as of 9:08 a.m. on 3/17/22. NA-K revealed they only had two aides on shift to care for all the residents on the second floor and he did not have time.

Interview on 3/17/22, at 1:10 p.m. NA-Z revealed he was responsible for caring for R12. He revealed he did not get R12 out of bed and put him in his chair on 3/16/22 or 3/17/22, because he did not know he was supposed to. He revealed he had a sheet of paper labeled "Group

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	245028	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 684	Continued From page 9 3," with R12's name on it. The paper revealed the resident was a Hoyer lift transfer, required feeding and fluid assistance, and to be repositioned every two hours. The paper lacked indication of putting R12 in his chair every morning in accordance with the "Physician's Order." Interview on 3/17/22, at 6:16 p.m. with NP-LL revealed she was very familiar with R12. She revealed R12 was very alert and oriented and able to make his own decisions, however, because of his physical condition he was dependent on staff. She stated her expectation was that he be gotten out of bed and placed in his chair every day. She stated that she has even told staff to get him up while she was in the facility.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 686	F686 TREATMENT AND SVCS TO	3/28/22

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F 686	Continued From page 10 review, the facility failed to implement interventions to prevent pressure injuries for 1 of 1 resident (R23) who was at risk for pressure ulcers. This resulted in actual harm for R23 who developed multiple stage II pressure injuries. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): - Stage II pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) R23's admission Minimum Data Set (MDS) dated 1/28/22, indicated R23 had diagnoses which included diabetes and acute kidney disease. The MDS further identified R23 was at-risk for pressure injuries, however, had no documented pressure ulcers. R23 required extensive assistance with bed mobility and toileting. Additionally, R23 required mechanical assistance with transfers. A progress note dated 2/23/22, at 3:18 p.m. indicated R23 had a left buttock wound which measured 1.4 centimeters (cm) by 1.2 cm. A subsequent wound provider note dated 2/27/22, indicated staff reported R23 had a new wound to their left buttock and R23 was not eating well. It was documented R23's wound was a stage II pressure ulcer which measured 1.4 cm x 1.3 cm. No additional skin concerns were noted. treatment recommendations included cleansing the area and application of a foam dressing daily and as needed. Additionally, staff were to offload pressure every two hours, optimize glycemic control (blood sugar management), provide a	F 686	PREVENT/HEAL Pressure ULCERS Immediate corrective action: Wound care orders were clarified and updated for R23, and the treatment was provided in accordance with the current orders. Corrective action as it applies to others: An audit of residents with pressure ulcers, and others found to be at-risk for the development of pressure ulcers based on the most recent assessment, will be completed. Provider orders will be clarified as needed, updated in the resident□s medical record, and the residents care plan will be updated to addresses the presence of altered skin integrity, including interventions to promote healing and prevent new ulcers from developing. Prevent Recurrence: The policy for the treatment of pressure ulcers was reviewed and remains current. Nursing staff will be educated on the policy. Ongoing Monitoring: 5 random weekly audits will be completed to ensure necessary treatment and services to promote healing and prevent ulcers from developing are implemented based on the residents□ clinical condition. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meeting for ongoing recommendations. Monitored By: DON/Designee	

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pressure relieving mattress, offload heals, and optimize nutrition. The wound note further indicated the plan was discussed with facility staff.

A wound provider note dated 3/6/22, indicated R23's left buttock wound had no changes and no new skin concerns were noted. Further, recommendations remained unchanged from 2/27/22.

A physician order dated 3/7/22, indicated R23's left buttock wound required daily, and as needed, cleaning with wound cleanser and foam dressing.

Despite the aforementioned wound interventions being recommended, R23's care plan which was dated 2/2/22, lacked indication of the stage II pressure ulcer and directed staff to follow facility policies/procedures for skin breakdown, monitor R23's food intake, and conduct a weekly skin check on bath day.

A wound provider note dated 3/13/22, indicated R23's left buttock wound had no changes and staff reported no new skin concerns. On exam, a new wound on R23's scrotum was identified. Barrier cream to the scrotal wound would be trailed. The aforementioned treatment recommendations remained in-place in addition to application of barrier cream to the scrotum and peri area twice daily and with incontinent cares, protein supplement twice daily for wound healing. It was documented the plan was discussed with facility staff.

A progress note dated 3/15/22, indicated R23 had multiple open areas to their buttocks and scrotum area. A note was left for the provider in a

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communication folder for follow-up.

During an observation on 3/14/22, at 1:33 p.m. R23 was observed in bed. The head of the bed was elevated and R23 was eating lunch. R23's lower legs had pillows under them, however, heels were resting on the bed. No pressure relieving mattress was in-place.

On 3/15/22, at 1:01 p.m. a continuous observation was started and R23 was in bed. The head of the bed was elevated approximately 45 degrees. At 1:09 p.m. R23 lowered the head of his bed and was groaning and yelling out; no staff was present in the hallway at this time. At 1:44 p.m. R23 appeared to be sleeping, however, again yelled out at 1:52 p.m. Staff was observed delivering laundry outside of R23's room and did not respond. Additionally, licensed practical nurse (LPN)-V was seated at a desk near R23's room and had not responded. At 2:41 p.m. R23 yelled out and LPN-V and LPN-D responded. LPN-V adjusted and applied lotion to R23's legs. LPN-D exited the room to obtain pain medication. R23 verbalized, "need change." LPN-V continued to lotion R23's legs and feet. Subsequently, LPN-D returned and assisted LPN-V apply lotion to R23. LPN-D discovered a reddened blister on the outside of R23's left heel. LPN-V confirmed the area was a new blister. LPN-V applied skin prep to the blister and measured the wound which was 1 cm x 3 cm. A pillow was then placed under R23's legs, however, heels were not floating off the mattress. LPN-J then assisted and covered R23 with a sheet and put a bedside tray within reach. R23 again requested incontinence care. LPN-J informed R23 they would notify a nursing assistant to which appeared to upset R23 who verbalized, "You go, and they never come change

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me, you say you tell them, they never come. I have told them to clean and wash me and they say they will come back and don't come back." R23 then stated, "I call long time; nobody come." LPN-J reassured R23 a nursing assistant would come. At 3:05 p.m. nursing assistant (NA)-T entered R23's room and turned R23 to his left side. A wound to R23's left buttock, left lower buttock/thigh, and scrotum were noted as R23 provided incontinence care. All three wounds were open and a small amount of pink drainage was noted. No dressings were noted on any of the wounds. At 3:16 p.m. LPN-D and LPN-V stated R23's left buttock wound was new, but the scrotum and left lower buttock/thigh wounds were new. R23's left lower buttock/thigh wound measured 2 cm x 1.5 cm and the scrotum wound measured 1 cm x 2 cm. R23's wounds were cleaned and the buttock and thigh wounds were covered with a foam dressing. R23 was repositioned to left side and the continuous observation ended at 3:22 p.m. R23 still did not have a pressure relieving mattress.

During an interview on 3/15/22, at 3:25 p.m. NA-T stated R23 needed to be turned every few hours, but repositioning residents was not happening due to being short staffed. NA-T stated when skin problems were seen, it needed to be reported to the nurse, but sometimes agency staff did not report these issues. NA-T again stated she was not able to follow the skin policy as there was not enough help. NA-T stated, "The residents are suffering."

During an interview on 3/15/22, at 3:30 p.m.. LPN-D stated R23 should be repositioned more frequently and it was hard to complete cares as there was not enough staff to do so.

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F 686	Continued From page 14 During an observation on 3/16/22, at 12:51 p.m. R23 was assisted back to bed by NA-A and NA-B using a mechanical lift. As R23 was lifted, R23's incontinence product was noted to be half opened and frank blood dripped onto the floor and bed sheets. R23 was placed and bed and was repositioned side-to-side as the soiled linens were removed and replaced. R23's wounds were again not covered with a dressing and no barrier cream was seen. R23's wounds were observed to be oozing bloody drainage. NA-A cleaned R23's wounds with a disposable wipe and NA-B exited the room to notify LPN-V. NA-A then placed a clean incontinence product on R23 without applying a barrier cream. NA-B then returned to the room and stated LPN-V would complete a dressing change when dining was completed. The resident was on his back with the head of bed elevated. Pillows were also placed under R23's legs, however, R23's heels remained in contact with the bed. During an interview on 3/16/22, at 10:22 a.m. nurse practitioner (NP)-II stated R23 had a stage 2 pressure ulcer on left buttock and stage 2 pressure ulcer on scrotum. NP-II stated they had not been notified R23 had a new open area on left lower buttock/thigh, nor the blister on R23's left foot. NP-II stated barrier cream needed to be placed on R23's scrotum and a foam dressing to their buttocks. NP-II stated the blister also needed to be protected or the skin was at-risk for further deterioration. NP-II expected staff to carry out any wound treatment orders for R23. During an interview on 3/17/22, at 9:14 a.m. the director of nursing (DON) stated staff were expected to provide barrier cream and dressings	F 686		

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F 686	Continued From page 15 to R23's wounds as directed. The DON stated, typically, nurse managers rounded with the wound provider to ensure an understanding of recommended treatments and recommendations. The managers then updated the resident's orders and care plan. The DON stated it had been months since there was unit leadership at the facility therefore this was her responsibility. The DON confirmed the wound provider recommendations were not follow-up on as she needed to understand what interventions were recommended as there was not a unit manager. Facility policy titled Pressure Injury/Skin Integrity/Wound Management revised 11/16, directed residents who were at risk for or who have loss of skin integrity would receive appropriate treatment and services which may include specific physician ordered treatments, pressure relieving equipment, and repositioning as per resident assessment and care plan. The policy also directed an avoidable pressure injury means the resident developed a pressure injury and the facility did not do one or more of the following: evaluate the residents clinical condition and risk factors, implement interventions that are consistent with the residents needs, goals and standards of care, monitor and evaluate the impact of the intervention.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		4/12/22

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F 689	Continued From page 16 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and policy review, the facility failed to ensure one resident (R15) had secured potentially hazardous materials out of a survey sample of 17. R15 had bleach in her bathroom. This had the potential for residents who were confused and wandered to have access to the hazardous material. In addition. R15 was known to leave the facility while burning tea lights. This had the potential to start a fire in the facility and placed 37 residents at risk who resided on the second floor with R15. The facility also failed to implement fall prevention measures for R51 out of a survey sample of two. Findings include: 1. Review of R15's quarterly "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" 01/12/22 indicated R15 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R15 was cognitively intact. Observation was conducted on 03/16/22 at 10:43 AM of R15's room. The room contained two wax burners with burned out tea lights located at the bottom of each burner. The Registered Dietician (RDFF) was present and confirmed R15's room contained two wax burners. One burner was located on the residents beside table and the second one was across from the resident's bed. R15 was not present during this observation. Observation was conducted on 03/16/22 at 11:36 AM, with Regional Sales and Marketing CC and	F 689	F689 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (E) Immediate corrective action: The bleach and candle wax burners were removed from R15s room. The fall mat was placed at the resident□s bedside for R51. Corrective Action as it Applies to Others: Environmental rounds will be completed of other resident rooms to ensure potentially hazardous chemicals, and candle wax burners are not present. Hazardous chemicals, and candles will be removed from resident rooms upon discovery. Housekeeping will monitor resident rooms daily for the presence of hazardous chemicals, or candles and remove them upon discovery. Prevent Recurrence: The policy and procedure for Accident Hazards was reviewed and remains current Staff will be educated on the policy. Ongoing Monitoring: 5 random weekly room audits will be completed of resident rooms to ensure they are free of hazardous chemicals, and candles. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meeting for ongoing recommendations.	

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F 689	Continued From page 17 the Director of Nursing (DON) entered R15's room. R15 was not present in her room. The DON and the Regional Sales and Marketing CC stated they were not aware R15 used wax burners in her room. Regional Sales and Marketing CC took the wax burners from R15's room. Observation in R15's bathroom contained a quart of "Homeline" bleach. During an interview on 03/16/22 at 12:13 PM, the Administrator confirmed she was the head of housekeeping (Housekeeping R). At 12:16 PM, Housekeeping R entered the conference room and confirmed she has observed the wax burners in R15's room. Housekeeping R stated she will find the tea lights lit and R15 has already left the facility. Housekeeping R stated she did not blow them out since she did not want R15 to yell at her. Housekeeping R stated she has seen the bleach in R15's room and Housekeeping R stated R15 does her own laundry outside of the facility. Housekeeper stated R15 did not have a locked cabinet to keep the bleach in. Review of a document provided by the facility titled "Safety Data Sheet," for "Homeline Regular Bleach Concentrated," dated 01/29/18 indicated ". . .This chemical is considered hazardous...Keep container tightly closed in a dry and well-ventilated place. Keep out of the reach of children. . ." Review of a policy provided by the facility titled "Accident Hazards/Supervision/Devices," dated March 2021, indicated ". . .It is the policy of Health Dimensions Group (HDG) communities to implement a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the	F 689	Monitored By: DON/Designee	

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likelihood of accidents. . .HDG communities provides an environment that is free from accident hazards over which the facility has control and provides supervision. . .evaluating hazard(s) and risk(s). . .Evaluating and analyzing hazard(s) and risk(s). . .Engaging staff, residents, and families in training on safety, and promoting ongoing discussions about safety with input from staff, as well as residents and families. . ."

2. Review of R51's EMR under the "Medical Diagnosis" tab revealed the resident had diagnoses of mental disorders, cognitive impairment, weakness, dementia without behavioral disturbances, and atrophy (muscle wasting).

Review of R51's significant change "MDS" with an ARD of 02/22/22 located in the EMR under the "MDS" tab revealed the resident was totally dependent on staff for transfers, dressing and locomotion and an extensive assistance with bed mobility. A "Cognitive Assessment" dated 03/09/22 located in the "Assessment" tab in the EMR identified the resident as having severe cognitive impairment.

Review of a "Post Fall Review" dated 12/06/21 located in the "Misc" tab of the EMR revealed R51was observed on the floor. According to the report she had fallen out of bed. The report revealed she had experienced one to three falls in the past three months. According to the review the resident was dependent on staff for Activities of Daily Living (ADLs) due to weakness and had been noted to have less trunk control and frequently leans to the left side. The review revealed the use of fall mats was added to the "Plan of Care."

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F 689	Continued From page 19 Review of R51's "Plan of Care" located under the "Care Plan" tab in the EMR with a revision date of 03/07/22 revealed she had a focus area which revealed the resident had an actual fall with no injury due to poor balance. The new fall interventions included to place a floor mat on the side of the resident's bed. On 03/15/22 R51 was observed in bed in her room without any staff present and without a fall mat on the floor from 12:50 PM through 1:51 PM. At 1:51 PM the resident began moving around in her bed and Nurse Aide (NA) Z was notified that R51 was in bed without the mat present. He verified the mat was not in place and placed the mat on the floor on the left side of the bed. On 03/16/22 R51 was observed in bed in her room with no staff present and without a mat next to her bed from 5:25 AM to 5:46 AM. At 5:46 AM the resident began to move around in bed and NAS was notified the resident did not have a mat down. He verified she did not have the mat next to her bed and put it in place on the left side of the bed. On 03/17/22 at 8:29 AM the Director of Nursing (DON) revealed R51 was supposed to have a mat in place on the left side of the bed whenever she was in bed without staff in the room in accordance with the "Plan of Care."	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		4/12/22

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F 692	Continued From page 20 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor weights for 3 of 3 residents (R22, R15, R45) who were reviewed for nutrition. Findings include: R22's admission Minimum Data Set (MDS) dated 11/1/21, indicated R22 was cognitively intact and had diagnoses of cellulites, lymphedema, and unspecified protein-calorie malnutrition. R22's orders lacked evidence for nutritional supplement and weight orders. R22's nutritional assessment dated 11/3/21, indicated R22 had stable weight at 166 pounds, but weight changes may be expected due to lymphedema and skin was intact.	F 692	F692 NUTRITION/HYDRATION STATUS MAINTENANCE Immediate corrective action: Nutritional supplement and weight orders were added for R22. A weight was obtained for R15, and R45 and orders have been obtained for weekly weights. Corrective Action as it Applies to Others: An audit will be conducted to ensure other residents have current weights documented in the EMR. Weights will be obtained for residents without a current weight. The dietician and provider will be updated of any significant weight changes. Monthly weight orders, unless otherwise specified by physician order, or dietician recommendations, will be obtained for	

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F 692	Continued From page 21 R22's weight summary printed 3/17/22, indicated R22 weighed 143.8 pounds on 12/13/21. R22's next documented weight was on 3/16/21 at 133.0 pounds. This left a severe weight change of 7.51%. R22's care plan dated 11/3/22, indicated R22 had potential for altered nutrition and would maintain nutrition as evidence by a stable weight of +/- 5% of 163 pounds. The intervention listed was to monitor and record weight per facility protocol. A provider note dated 2/23/22, indicated "encourage protein supplements twice a day". During an interview on 3/16/22, at 9:30 a.m. registered dietitian (RD)-FF stated resident nutrition assessments were based off resident and staff interview and the MDS. Any indicated treatment recommendations were communicated to him from the director of nursing (DON). RD-FF used this information to determine dietary needs from there. RD verified R22 has not had a weight since December and overall weights were inconsistent in the facility. RD's expectation was for weights to be completed monthly unless a resident had a specific order. RD further stated it was important to track residents' weights as it was an important to help determine needs and nutritional status. RD had sent out a communication to the DON about missing weights but was unsure if there was follow up. During an interview on 3/16/22, at 3:15 p.m. nursing assistant (NA)-T stated weights were supposed to be done on bath days, but there wasn't enough time to complete baths most days. Since baths were not completed, weights were	F 692	residents to ensure ongoing weight monitoring. Prevent Recurrence: The policy and procedure for weight loss was reviewed and remains current Nursing staff will be educated on the policy. Ongoing Monitoring: 5 Random weekly audits will be completed to ensure resident weights are being obtained. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meeting for ongoing recommendations. Monitored By: DON/Designee	

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not done. NA-T stated there was not enough staff to complete these cares.

During an interview on 3/16/22, at 3:22 p.m. NA-A stated resident weights are completed on bath days if there was no specific order. NA-A verified weights were getting missed as "we try to get the baths, but do not have time to always get a weight". NA-A verified it was a long time since R22 had a weight and would try to get one this shift.

During an interview on 3/17/22, at 9:31 a.m. DON stated nutritional assessments were completed upon admission and quarterly unless there was a significant change. DON verified R22 had no weight obtained since December, until the state agency (SA) requested one. DON stated R22's weight was a significant change. Furthermore, staff were expected to obtain weights once a month on bath days. DON stated if weights were obtained and tracked, the dietitian would have been notified to better understand what was happening and try to prevent or reverse the weight loss.

During an interview on 3/17/21, at 5:53 p.m. nurse practitioner (NP)-LL stated R23 was at nutritional risk as anyone with skin breakdown was at risk. NP stated her expectation was for weights to be completed monthly at a minimum. NP-LL further stated R22's weight change may have been due to decreasing edema, but R22 had been stable recently. NP-LL stated having weights obtained for R22 would provide a better understanding of the weight loss and if it was related to fluids or nutritional status.

A facility policy titled Weight Loss revised on

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5/2020, indicated residents will not fall below their ideal body weight unless weight loss was viewed as unavoidable and dietary and nurses notes would address weight loss issues.

Review of R15's electronic medical record (EMR) undated "Admission Record," located under the "Profile" tab, indicated R15 was admitted to the facility on 07/14/21, with a diagnosis of type II diabetes mellitus.

Review of R15's EMR "Care Plan," located under "Care Plan" tab dated 09/12/21 indicated the resident was nutritionally at risk and to provide the resident a consistent carbohydrate diet. The goal for R15 was to increase her weight by three to four pounds a month until she reached an ideal body weight. The care plan directed staff to weigh R15 per weight protocol.

Review of R15's EMR "Dietary Progress Notes," located under "Prog (Progress) Notes," dated 07/21/21 indicated that R15 was recently admitted to the facility and there was no dietary information from the hospital. The registered dietician (RD)-FF progress notes indicated (RD)-FF recommended a carbohydrate-controlled diet. The RD-FF's progress notes indicated the resident had the potential for altered nutrition related to diagnosis. On 10/20/21, (RD)-FF indicated R15 had no weights taken for the past month. The (RD)-FF indicated R15 exhibited adequate nutrition as evidenced by good intake records. On 11/10/21, (RD)-FF noted he attempted to meet with R15 for education for a carbohydrate-controlled diet but indicated the resident was unavailable at this time and would attempt to reach out to R15 within one week. On 11/24/21 the (RD)-FF indicated in the progress

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notes another attempt was made to meet with R15 the week prior as well as today and the resident was not at the facility. RD-FF noted he was informed by staff R15 was at an appointment and the (RD)-FF left material for the resident to read on carbohydrates and to ask questions upon further education request.

Review of R15's EMR "Weight Summary," located under "Weights and Vitals" tab dated 09/02/21 indicated the resident's weight was 110 pounds (lb). This was the last weight taken for R15.

During an interview on 03/16/22. at 9:00 a.m. housekeeping (H)-R who was also the administrator stated she was aware R15 would prepare her own meals. (H)-R stated she would frequently find rotten food in R15's room and even saw R15 defrost ribs while sitting in the resident's sink with water running over the meat. (H)-R stated she has observed R15 cook her own meals in the main dining room microwave on the second floor. At 9:06 AM, R15's room was observed, and the resident permitted surveyor to open her refrigerator. The refrigerator was full of food items. R15 confirmed she prepared her own meals and even cooked the night prior.

During an interview on 03/17/22, at 8:26 a.m., the director of nursing (DON) stated previously she was not aware R15 was preparing her own meals. The DON stated she was not sure if the physician and (RD)-FF were alerted to R15's behavior of preparing her own meals. The DON confirmed R15 was a nutritional at risk. While reviewing the clinical progress notes for R15, the DON confirmed that and (RD)-FF did not assess R15 her high blood sugars or her diet.

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F 692	Continued From page 25 During an interview on 03/16/22, at 10:22 a.m., (RD)-FF stated he comes out to the facility on a weekly basis. (RD)-FF stated he considered R15 to be nutritionally at risk and he was not informed R15 prepared her own meals and was not consuming meals prepared by the facility. The (RD)-FF confirmed R15 had no weights taken by the facility since September 2021. (RD)-FF stated he would have provided R15 education on preparing meals for herself and her diagnosis of diabetes mellitus. During an interview on 03/16/22, at 10:34 a.m., dietary director (DD)-U was asked if R15 had food complaints. (DD)-U stated she was aware R15 left the facility a great deal and would bring food back and was not aware R15 prepared her own meals in the facility microwave. During a subsequent interview on 03/16/22, at 10:42 a.m. (RD)-FF stated he has attempted to meet with R15 and was unsuccessful for diabetic meal education and might benefit from this type of education. During an interview on 03/17/22, at 5:23 p.m., nurse practitioner (NP)-II stated she was aware R15 was preparing meals for herself, and the meal selection was terrible for the resident and for her diagnosis of diabetes. (NP)-II stated she has observed R15 reheat fried chicken and was aware R15 would leave the facility for multiple days. (NP)-II stated R15 was a challenge to take care of. NP II stated she has discussed R15's case with the prior DON. (NP)-II stated education needed to happen in an attempt for R15 to make the correct decisions.	F 692		

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Review of a policy provided by the facility titled "Weight Loss," dated May 2020, indicated ". . .The facility ensures that residents who enter the facility will not fall below their ideal body weight range, unless the weight loss is viewed as unavoidable. . .Dietary consult completed, and suggestions implemented. . ."

Review of R45's admission sheet located in the EMR revealed his diagnoses included metabolic encephalopathy (neurological disorder), acute respiratory failure, dysphagia oropharyngeal phase (difficulty in swallowing), protein-calorie malnutrition, and hypernatremia (high sodium levels).

Review of the "Orders" tab in R45's EMR revealed he was admitted to the facility on 12/12/21, with an admitting order for nothing by mouth (NPO) and an order for Promote with fiber via J tube (tube to deliver food) for 16 hours to start at 6:00 PM and off at 10:00 AM. He also had an order for a J-port flush of 120 milliliters (ml) of free water before and after each tube feeding cycle.

Review of his "Nutritional Plan of Care" located under the "Care Plan" tab of the EMR revealed he did not have a "Nutritional Care Plan" initiated until 02/18/22, two months after he was admitted to the facility, he did not have a "Nutritional Assessment" until 02/16/22, and as of 03/14/22 he had not had any weights obtained during his stay at the nursing facility. The first and only "Nutritional Progress" note/assessment located in R45's EMR and paper medical record was dated 02/16/22, at 11:59 p.m..

The "Nutritional Progress Note" located under the

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F 692	Continued From page 27 "Progress Note" tab of the EMR dated 02/16/22, at 11:59 p.m. revealed, "RD [Registered Dietician] reviewed the resident for a Significant Change "Minimum Data Set (MDS)" with and Assessment Reference Date (ARD) of 02/17/22. Resident has no significant weight changes noted d/t [due to] no weight in facility; nursing has been notified. Weight changes expected r/t [related to] need for enteral nutrition [feeding that uses the gastrointestinal (GI) tract]. Resident receives enteral nutrition with orders for Promote w/fiber 75ml/hour for 16 hours from 1800-1000 [6:00 PM to 10:00 AM], 120ml free water flush b/a [before/after] feedings providing 1200kcal [calories], 75.6g[grams] protein, and 1237ml free water meeting most of her daily estimated nutritional needs; current orders are a continuance from hospital orders. A video swallow study has been ordered. Skin contains areas of concern. RD has requested a new weight to help determine changes needed for enteral nutrition. Potential for altered nutrition related to dx/hx [diagnoses/history]. RD will F/U [follow up] per "MDS" or PRN [as needed]. Review of the "Plan of Care" for nutrition located in the "Care Plan" tab of the EMR with an initiated date of 02/18/22 was reviewed. The focused area of the care plan revealed the resident had the potential for altered nutrition due to having a history of metabolic encephalopathy, acute respiratory failure, dysphagia, protein-calorie malnutrition, hypertension, and the need for enteral nutrition. The goal was for R45 to maintain a stable weight of 111 pounds (lb) plus or minus 5% and to tolerate the enteral nutrition as ordered. The interventions included monitor/record weight per facility protocol and provide enteral nutrition as ordered.	F 692		

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On 03/15/22 the resident's EMR and paper records were reviewed in their entirety and did not include a recorded weight while in the facility.

On 03/15/22, at 1:33 p.m. the weights located under the "Vital Signs" tab in the EMR were reviewed with nurse aide (NA)-K. He stated he was a full-time day shift employee and usually worked on the unit R45 resided on. He verified the resident had not had a weight obtained while residing in the facility and stated the weights should be obtained when residents receive their baths at least once a month however due to being short staffed, they often are unable to obtain the weights.

On 03/15/22, at 1:40 p.m. registered nurse AA (RN)-AA was interviewed about the weights, and he verified the resident had not had a weight recorded at all since being admitted to the facility. He stated each resident should be weighed at least once a month. He had the resident weighed and the resident's weight was then recorded as 103 lb.

On 03/16/22, at 8:28 a.m. (RD)-FF was interviewed. He stated getting weights was an issue at the facility. He stated he had a lot of residents who have not had their weights obtained in a while and as a result he was not able to complete an accurate nutritional assessment on the residents including R45. He stated since the resident had not been weighed since admission, he used the only weight he found in the hospital records. He stated he obtained the 111 lb weight from the "Hospital Referral" document dated 12/16/21. Review of the document titled "Regions Hospital" located in

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the "Misc" tab in the EMR and dated 12/16/21 revealed his weight was recorded in the document as 111 lb. (RD)-FF stated if the resident went from 111 lb to 103 lb from 12/16/21 to 03/15/22 that would represent a 7.8% weight loss and he stated he would consider that to be a significant weight loss. He stated that if he had received the information earlier, he would definitely have adjusted his tube feeding to ensure it provided additional calories. He stated the resident should have been receiving 25 to 35 calories per kilograms of body weight and that would mean he should have received between 1170 calories and 1639 calories. He stated the residents current feeding was providing 1200 calories and he would be recommending an increase since he lost weight.

On 03/17/22, at 8:43 a.m. the DON verified R45 had not been weighed and that the resident's nutritional status and needs were not assessed until 02/16/22. She did not provide a written weight protocol however she stated residents should be weighed monthly and two times a month if they are on a tube feeding.

Review of the facility's "Enteral Nutrition and Hydration" policy with an origination date of November 2016 revealed it was the facility's policy for residents who receive assisted nutrition and hydration to maintain acceptable parameters of nutrition, such as usual body weight or desired body weight unless the resident's clinical condition demonstrates that this is not possible. The policy defined assisted nutrition and hydration to include gastrostomy tubes and percutaneous endoscopic jejunostomy tubes and enteral fluids.

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F 692	Continued From page 30 Review of the facility's "Weight Loss" policy with a reviewed date of May 2020 revealed, "the facility ensures that a resident who enters the facility will not fall below their ideal body weight range, unless the weight loss is viewed as unavoidable." The policy was silent to how often weights should be obtained but stated the charts should contain the current weight.	F 692		
F 725 SS=F	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 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.	F 725		4/12/22

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F 725	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient staffing to ensure residents received care and assistance they needed. This had the potential to affect all 57 residents who reside in the facility. Findings include: Refer to F677: the facility failed to ensure a resident who is unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene for 1 of 1 resident who expressed concern regarding bathing. Refer to F684: the facility failed to ensure 1 of 1 resident (R12) was transferred out of bed per physician order and per resident request. Refer to F686: the facility failed to implement interventions to prevent pressure injuries for of 1 of 1 resident (R23) who was at risk for pressure ulcers. This resulted in actual harm for R23 who developed multiple stage II pressure injuries. Refer to F692: Based on observation, interview and document review, the facility failed to monitor weights for 3 of 3 residents (R22, R15, R45) who were reviewed for nutrition. Refer to F756: Based on interview and document review, the facility failed to ensure pharmacist recommendations were addressed or had a rational documented for not implementing recommendations for 3 of 5 residents (R12, R15, R21) reviewed of unnecessary medications.	F 725	F725 SUFFICIENT NURSING STAFF Immediate Corrective Action: R12 was transferred out of bed and received a bath per his preference. Wound orders were clarified for R23, and wound treatment was provided. Weights were obtained for R22, R15, and R45 Pharmacist recommendations were addressed for R12, R15 and R21. Corrective Action as it Applies to Others: The Executive Director, Director of Nursing, and Staffing Coordinator or their respective designees will meet 3x weekly to discuss staffing levels, and review staffing schedules to ensure sufficient nursing staff are available to adequately meet residents needs. Prevent Recurrence: Staff will be educated on adequate supervision and aiding with meeting resident needs. Ongoing Monitoring: 5 Weekly audits will be completed to ensure resident ADL needs are met, resident weights are obtained, pharmacy recommendations are completed timely, and wound cares are completed as ordered. A Summary of audit results will be reviewed during the monthly QAPI meeting for the next 60 days for further recommendations. Completed By:	

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F 725	Continued From page 32 During an interview on 3/14/22, at 1:45 p.m. R18 stated there were no nursing assistants (NA) working for a while this morning and believed there was only one working currently. R18 further stated residents helped staff by taking their trays to the tray cart after lunch. During an interview on 3/14/22, at 1:58 p.m. R258 stated there was only one NA for the entire first floor at night. Furthermore, some nights R258 had to wait until 7:00 a.m. to be changed as it took 2-3 staff to change her and there wasn't enough on to be changed at night. During an interview on 3/14/22, at 4:58 p.m. R1 stated on 3/13/22 he laid in a dirty brief all night because there was not enough NAs working to help. During an interview on 3/14/22, at 12:54 p.m. R46 stated there was not enough staff and there were long waits. R46 further stated they stopped asking for more water as staff were too busy to get bring it. During an interview on 3/14/22, at 12:18 p.m. R7 stated staff were short at times. R7 further stated on two Saturdays ago, residents were still in bed at 1:00 p.m. with their hospital gowns still on. During an interview on 3/18/22, at 3:22 p.m. NA-T stated staff are leaving the facility due to increased pay elsewhere. The agency staff often show up late and sometimes don't arrive until 9:00 a.m. NA-T stated there haven't been any floor managers for months so there were not any follow upon being completed. NA-T further stated there was not enough time to complete showers or weights. "There just not enough help".	F 725	Don/Designee	

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During an interview on 3/15/22, at 9:55 a.m. assistant executive director (AED) stated resident cares may be delayed this day due to a nurse not showing up. AED asked state agency to attempt to observe wounds the following day when there was extra staff present for wound rounds.

During an interview on 3/14/22, at 12:57 p.m. licensed practical nurse (LPN)-J stated they were not able to get their work done and they were the only regular staff nurse on for the day. LPN-J further stated there was supposed to be 4 NAs on the second floor, but there was only 2. LPN-J inquired if the national guard was coming to help.

During an interview on 3/17/22, at 9:14 a.m. the director of nursing (DON) stated there were times resident updates from the provider were conversations that occurred and subsequently had not been documented in their medical record. DON further acknowledged the lack of documentation may limit information from other members of the interdisciplinary team and lead to a lack of appropriate interventions placed. DON stated staffing challenges were hard and currently there were no nurse managers to aid in communication and care plan updates and all was left for her to complete.

During an interview on 3/17/22, at 1:38 p.m. the assistant executive director (AED) stated they were aware of some agency coming in late, due to working on the night shift at hospitals the night before and were not able to arrive on time. The AED was trying to address this. AED further stated most agency staff are here on time. During the week the AED had been at the facility, staff had not come to address being unable to

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F 725	Continued From page 34 complete tasks assigned and had not heard of complaints from residents. The staffing coordinator stated incentives and bonus programs are in place for picking up shifts and for not calling off shifts. During a follow-up interview on 3/17/22, at 3:02 p.m. the DON stated there was centralized recruiting through the corporate office. At one point, the facility had elimination of agency use, but with the pandemic, agency staff was needed. DON and AED stated the problem was known, and they would be working with the medical director in QAPI to develop a sustainable action plan.	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	F 756		4/12/22

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F 756	Continued From page 35 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pharmacist recommendations were addressed or had a rational documented for not implementing recommendations for 3 of 5 residents (R21, R15, R12) reviewed of unnecessary medications. Findings include: R21's admission Minimum Data Set (MDS) dated 1/22/22, indicated R21 was cognitively intact and had diagnoses of diabetes, cellulitis, and weakness. R21's provider orders dated 1/15/22, indicated R21 had hydroxyzine (medication for anxiety) 50 milligrams (mg) by mouth every four hours as needed for anxiety or pain ordered. The facility report titled Consultation Report dated	F 756	F756 DRUG REGIMEN REVIEW, ACT ON Immediate corrective action: The pharmacy recommendations for R21, R15, and R12 were reviewed with the provider. The Hydroxyzine order for R21 was discontinued and a Self-Administration assessment was completed for R15. An AIMS assessment was completed for R12, the order for guaifenesin was discontinued, and the provider clarified the indication for use for R12s quetiapine order. Corrective Action as it Applies to Others: The DON or Designee will log pharmacy recommendations upon receiving them from the consultant pharmacist and forward recommendations to the respective providers. The DON or	

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F 756	Continued From page 36 2/11/22, indicated the consulting pharmacist recommended R2's hydroxyzine order to be discontinued due to low use and concurrent opioid use. R21's medical record lacked evidence of this recommendation was addressed by the provider. During interview on 3/17/22, at 9:20 a.m. the director of nursing (DON) stated she received the pharmacist recommendations each month and was responsible for any nursing portion of the recommendation. DON further stated the provider information was given to them and she was not sure where they documented. DON confirmed R21's recommendation was not acted upon as DON had not reviewed any recommendations for 2/2022. A facility policy titled Drug Regimen Review and Services Consultation revised 9/22/17, directed a written report was to be submitted and signed by the consulting pharmacist to the DON. The attending physician must then document in the resident's medical record the irregularity was reviewed and any actions taken to address it. Review of R15"s electronic medical record (EMR) undated "Admission Record," located under the "Profile" tab, indicated R15 was admitted to the facility on 07/14/21. Review of a document provided by the facility titled "Consultant Report," dated 01/10/22, indicated R15 lacked information on the self-administration of insulin. The pharmacist noted, R15 ". . .has an order for "OK" to self-administer insulin and to keep at bedside. . .For individuals requesting to self-administer	F 756	designee will routinely monitor the log to ensure pharmacy recommendations are addressed by the providers within 30 days of the recommendation or sooner if indicated by the pharmacist. Once completed by the provider, the recommendations will be acted upon based on the providers response. Completed pharmacy recommendations will be entered into the resident EMR when complete. Prevent Recurrence: The policy for Pharmacy Services was reviewed and remains current. The DON/Designee will be reeducated on the policy. Ongoing Monitoring: A weekly audit of the pharmacy recommendation log will be conducted to ensure recommendations are completed timely. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meeting for ongoing recommendations. Monitored By: DON/Designee	

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medications, it is the responsibility of the facility interdisciplinary team to. . .Determine and document that it is safe for the individual to self-administer medications. . .Determine and document who is responsible for storage and documentation of medications administration. . .Determine and document the location of medication administration (nurse's station vs. individual's room. . ."

During bservation on 03/14/22, at 1:10 p.m., R15 presented two insulin pens and confirmed she self-administered herself insulin.

Review of the EMR clinical records for R15 failed to indicate a self-administration assessment was completed by staff.

During an interview on 03/17/22, at 8:26 a.m. the director of nursing (DON) confirmed there was a physician order dated 11/02/21 for R15 to self-administer her insulin. The DON confirmed there was no interdisciplinary (IDT) note which would indicate the IDT team met and assessed R15 for the safe self-administration of her insulin. The DON confirmed R15 completes her own finger stick to obtain a blood sample to test her levels of glucose in her blood. The DON confirmed the self-administration assessment should have been completed on a quarterly basis and this was not done. The DON confirmed the pharmacy recommendations dated 01/10/22 were not completed. The DON stated there was a prior DON in place at this time. The DON stated the pharmacy recommendations should have been completed within 30 days.

Review of a policy provided by the facility titled "Pharmacy Services [General]" dated May 2020,

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indicated ". . .The community pharmacy provides routine and emergency drugs and biologicals to the residents. . .If any irregularity is noted during the DRR [Drug Regimen Review], the pharmacist is required to notify the attending physician, DON [Director of Nursing], and medical director. . .The DON will ensure that all recommendations are followed through on a timely basis, which does not exceed 30 days. . ."

2. Review of the facility policy titled "Pharmacy Services [General]" with a reviewed date of May 2020 revealed it was the facility's policy for the pharmacist to complete a Drug Regimen Review monthly and for the attending physician to document in the resident's medical record that the irregularities were received and what action was taken to accommodate it. The policy revealed irregularity includes, but is not limited to, the use of any drug that meets the criteria for unnecessary drug.

Review of the pharmacy "Consultant Reports" provided by the facility for 02/11/22 through 02/14/22 revealed the pharmacist made the following recommendations for R12:

a. The pharmacist report revealed R12 received quetiapine (antipsychotic) which may cause involuntary movements including tardive dyskinesia (uncontrollable movements) and recommended the facility monitor for involuntary movements (AIMS) "now and at least every six months."

b. The pharmacist report revealed R12 was receiving quetiapine 125 milligrams (mg) TID (three times a day), without documentation of diagnosis and adequate indication for use, in the

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medical record and recommended the medical record be updated to include the specific diagnosis/indication requiring treatment that is based upon an assessment of the resident's condition and therapeutic goals; a list of symptoms or target behaviors (e.g., hallucinations, scratching) including their impact on the resident (e.g., increased distress, presents danger to self or others) and; document other nonpharmacological interventions and medications considered.

c. The pharmacist report revealed R12 had received a routine cough/cold product for more than 14 days as he had a 01/05/22 order for guaifenesin tablet 600 mg two times a day for cough. The pharmacist recommended the medication be discontinued when the cough subsides.

Review of R12's EMR and the paper medical record revealed no documented evidence to show the attending physician reviewed and/or acted upon the recommendations.

The record did not contain an appropriate diagnosis, adequate indication for use, and for the AIMS test related to the uetiapine order. In addition, the resident remained on the guaifenesin for a cough. The "Progress Notes" located under the "Progress Notes" tab in the EMR were reviewed for February and March 2022 and did not contain reference to the resident experiencing a cough.

During interview on 03/17/22, at 9:20 a.m. the DON revealed the physician had reviewed the pharmacy drug regimen reviews and agreed with all the recommendations; however, she failed to

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F 756	Continued From page 40 document and act on the agreed upon recommendations. She stated the reviews remained on her desk and the pharmacy recommendation and physician's approvals never made it to the medical record and were never acted upon. The regimen reviews provided did not contain any evidence the physician reviewed them.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		4/12/22

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F 758	Continued From page 41 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure prescribed medications had an adequate diagnosis documented and residents were monitored for an ordered antipsychotic medication for 1 of 5 residents (R12) reviewed for unnecessary medication ust. Findings include: Review of the "Physician's Orders" located in the electronic medical record (EMR) under the "Physician's Orders" tab revealed R12 had an order for quetiapine fumarate tablet (antipsychotic)125 milligrams (mg) three times a day with a start date of 01/05/22. The order revealed to monitor for behaviors, crying, and anxiety. To document Y if the behavior was noted and N if the behavior was not noted on each shift.	F 758	F758 FREE FROM UNNECESSARY PSYCHOTROPIC MEDICATIONS Immediate corrective action: An AIMS assessment was completed for R12, and the provider clarified the indication for use for R12s quetiapine order. Corrective Action as it Applies to Others: A review will be completed for other residents who receive antipsychotic medications to ensure they have current AIMS assessments, current behavior monitoring, and to ensure the use of antipsychotic medication has a diagnosis or indication for use of the medication. Recurring orders will be entered for residents who receive antipsychotic	

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F 758	Continued From page 42 The order revealed the medication was for the resident's diagnosis of cerebral palsy (disorder of movement, muscle tone, or posture). Review of the pharmacy reviews provided by the director of nursing (DON) for 02/11/22 through 02/14/22 revealed the pharmacist made the following recommendations for R12: The pharmacist wrote the quetiapine may cause involuntary movements including tardive dyskinesia and recommended the facility monitor for involuntary movements (AIMS test) "now and at least every 6 months." In addition, the pharmacist wrote R12 was receiving quetiapine 125mg TID (three times a day), without documentation of diagnosis and adequate indication for use, in the medical record and recommended the medical record be updated to include the specific diagnosis/indication requiring treatment that is based upon an assessment of the resident's condition and therapeutic goals; a list of symptoms or target behaviors (e.g., hallucinations, scratching) including their impact on the resident (e.g., increased distress, presents danger to self or others) and; document other nonpharmacological interventions and medications considered. The EMR and the paper medical record were reviewed in their entirety and did not contain documentation indicating the above recommendations had been acted on and did not contain an appropriate diagnosis and adequate indication for use. Review of the "Behavior Monitoring" documents	F 758	medications to alert staff at the time an AIMS assessment is to be completed. Prevent Recurrence: The policy for the use of Antipsychotic medications was reviewed and remains current. Licensed staff will be educated on the policy. Ongoing Monitoring: 5 weekly audits will be completed to ensure residents who receive antipsychotic orders have a diagnosis or indication for use, current behavior monitoring, and a current AIMS assessment. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meeting for ongoing recommendations. Monitored By: DON/Designee	

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F 758	Continued From page 43 located in the EMR under the "Orders" tab and review of all the "Nursing Notes" located under the "Progress Notes" tab in the EMR revealed no behaviors were documented on 17 days in January 2022, 22 days in February 2022 and 13 days in March 2022, as of 03/15/22. During interview on 03/17/22, at 9:20 a.m. the Director of Nursing (DON) revealed the physician had reviewed the pharmacy drug regimen reviews and agreed with all the recommendations however she failed to document and act on the agreed upon recommendations. She stated the reviews remained on her desk and the pharmacy recommendation and physician's approvals never made it to the medical record and were never acted upon. She also reviewed the behavior documentation and agreed it was not completed as ordered.	F 758		
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. §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.	F 761		4/12/22

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	245028	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 761	Continued From page 44 §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, staff interview, and facility policy review, the facility failed to ensure that one of four medication carts observed in the facility were locked when not in direct view of a staff member. This had the potential to put at risk all residents who resided in the facility that were able to access the 1st floor west hallway. Findings include: During observation on 03/16/22, at 6:20 a.m. the medication cart on the first floor West Wing was noted to be unlocked and no staff were in the area. The surveyor stayed with the cart until Nursing Assistant (NA)-O came down the hallway at approximately 6:25 AM. NA-O walked by the cart and the surveyor pointed out that the cart was unlocked. NA-O stated the cart should not be unlocked and pushed the lock closed on the cart. NA-O said he did not know where the nurse was who was responsible for the medication cart. During an interview on 03/16/22,at 6:38 a.m licensed practical nurse (LPN)-JJ confirmed he was responsible for the unlocked medication cart on the West Wing. He revealed he left it unlocked and went to give report on the East Wing.	F 761	F761 LABEL/STORE DURGS AND BIOLOGICALS Immediate corrective action: The medication care was locked once it was noted to be unlocked. LPN □ JJ received 1:1 education regarding locked medication carts. Corrective Action as it Applies to Others: Medication carts will be locked when not in direct observation of licensed staff. Prevent Recurrence: The policy for Medication Storage was reviewed and remains current Staff will be educated on the policy. Ongoing Monitoring: 5 weekly audits will be conducted on various units to ensure medication carts are locked in accordance with facility policy. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meeting for ongoing recommendations. Monitored By: DON/Designee	

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F 761	Continued From page 45 During an interview with the director of nursing (DON) on 03/16/22, at 12:59 p.m. the DON stated that it was her expectation that medication carts always be locked. Review of the facility policy, "Medications - Labeling and Storage" (revised May 2020) reflected "In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments ... and permit only authorized personnel to have access to the keys ... PROCEDURE ... 4. All medications will be stored appropriately, either in the locked medication cart or medication room.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (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:	F 812		4/12/22

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F 812	Continued From page 46 Based on observation, interview, record review the facility failed to ensure food in the refrigerator on the first-floor kitchenette was dated and failed to ensure the sanitizer container in the kitchen used to store wiping cloths and to sanitize food contact surfaces contained sanitizer at a strength that would effectively sanitize surfaces. This had the potential to affect 56 of the 57 residents of the facility. The facility identified one resident who received nothing by mouth (NPO). Findings include: During interview on 03/16/22, at 10:30 a.m. dietary director (DD)-U revealed the food brought in for residents was either stored in the refrigerators in resident rooms or in the refrigerator in the first-floor kitchenette. During observation on 3/16/22, at 10:35 a.m. the refridgerator in the first floor kitchenette did not contain a thermometer, therefore it was not possible to determine if the refrigerator was maintained at a safe temperature. The refrigerator contained the following items: A bag of lettuce salad that was not dated or labeled with a resident's name. An open quart container of "Hormel Thick and Easy" nectar consistency water with an open date of 03/03/22. The instructions on the side of the container stated to discard within 10 days of opening. The container was one-fourth full of the thickened water. An open "Hormel Thick and Easy" nectar consistency "Dairy Beverage" the container was three-fourth full. The container was not dated with	F 812	F812 FOOD PROCUREMNET, STORE/PREPARE Immediate corrective action: Undated, unlabeled, and outdated food items were removed from the kitchenette refrigerator and discarded. A thermometer was placed in the refrigerator. The Quat Sanitizer in the Kitchen was replaced. Corrective Action as it Applies to Others: Other refrigerators will be audited to ensure food items are labeled, dated when opened, and not outdated. The Quat Sanitizer will be tested and logged to ensure the solution is at a concentration as specified the per manufacturer□s recommendations each time a new solution is prepared. Prevent Recurrence: The policy for Food provided by Family/Visitors □ Sanitary Conditions was reviewed and remains current. Nursing/Culinary/Housekeeping staff will be educated on the policy. Culinary staff will be educated on the manufacturer□s recommendations for the use of Quat Sanitizer. Ongoing Monitoring: 5 weekly audits will be conducted to ensure the kitchenette refrigerator is clean and food items are stored in accordance with facility policy and to ensure the Quat Sanitizer solution concentration is being monitored and recorded. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meeting for	

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F 812	Continued From page 47 an opened date. The instructions on the back of the container stated to discard within four days of opening. An open quart container of "Hormel Thick and Easy" nectar consistency water. The container was not dated to indicate what date it was opened. The instructions on the side of the container stated to discard within 10 days of opening. The container was half full of the thickened water. An open quart container of "Hormel Thick and Easy" nectar consistency apple juice. The container was not dated to indicate what date it was opened. The instructions on the side of the container stated to discard within 10 days of opening. The container was three-fourths full of the thickened water. An open container of "Lactaid whole Milk" dated 02/20/22, which was about half full. The instructions on the container stated to discard within 14 days of opening. An open and partially used 4-ounce package of cream cheese. The cream cheese was not labeled or dated. Health Information Employee (HIE)-P was present during the observation and verified the food was not labeled or dated and there was no thermometer in the refrigerator. Review of the facility policy titled "Food provided by Family/Visitors-Sanitary Conditions" with dated May 2020 revealed it was the facility policy for food to be dated, labeled, and stored in accordance with professional standards for food	F 812	ongoing recommendations. Monitored By: DON/Designee	

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F 812	Continued From page 48 service safety. During observation and interview on 03/16/22, at 11:03 a.m. revealed cook (C)-A went to the three-compartment sink and filled a red container with water and placed a wiping cloth in it. He used the cloth out of the container to wipe off the counter he had just pureed the chicken on. At 11:15 AM he used the wiping cloth out of the container to wipe the counter where he had just removed chicken off a pan. Interview with C-A at the time of the observation revealed it was quat sanitizer and he was using it to clean and sanitize the food preparation surfaces. He tested the solution and it measured zero parts per million (ppm). He verified it was zero ppm and stated it should have been at least 150 ppm. He dumped out the liquid and prepared a second container which also measured zero ppm. The container of quat sanitizer under the three-compartment sink was very low and the solution was not going through the tubing and was not mixing with the water therefore no sanitizer was coming out. C-A verified the water was not being mixed with the sanitizer. During interview on 3/16/22, at 11:17 a.m. with dietary director (DD)-U revealed C-A should have tested the strength of the solution in the red container prior to using it to sanitize the food contact surfaces. A policy was requested and on 03/17/22, at 10:53 a.m. and assistant executive director (AED)-GG stated they did not have a policy related to storing wiping cloths and the sanitizing solution in the red containers. Review of the manufacturer's instructions titled	F 812		

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F 812	Continued From page 49 "Chem Quat Sanitizer" posted on the wall above the three-compartment sink revealed the quat sanitizer solution should have been 150 to 400 ppm to sanitize dishware and food contact surfaces.	F 812		
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the food a resident brought in from the outside was dated and labeled. The facility further failed to ensure temperature logs were maintained for a resident who had a personal refrigerator in her room. This had the potential to affect one of eight residents (R15) reviewed who had personal refrigerators in their rooms. Findings include: Review of R15's electronic medical record (EMR) undated "Admission Record," located under the "Profile" tab, indicated R15 was admitted to the facility on 07/14/21. Review of R15's quarterly Minimum Data Set (MDS) with an "Assessment Reference Date (ARD)" 01/12/22 indicated R15 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R15 was cognitively intact.	F 813	F813 PERSONAL FOOD POLICY Immediate corrective action: Unlabeled and undated food items were removed and discarded for resident R15. A thermometer was placed in the refrigerator. Corrective Action as it Applies to Others: Other resident refrigerators will be audited to ensure food items are labeled, dated when opened, and stored properly. Education regarding food storage will be provided to residents. Housekeeping staff will monitor resident rooms daily to ensure food items are stored, labeled, and dated properly. Prevent Recurrence: The policy for Food provided by Family/Visitors □ Sanitary Conditions was reviewed and remains current. Nursing/Culinary/Housekeeping staff will be educated on the policy.	4/12/22

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F 813	Continued From page 50 During an interview on 03/16/22, at 9:00 a.m., housekeeper (H)-R stated she has found multiple food items in R15's room, including thawing raw meat in R15's sink located in her bathroom. H-R stated R15 would run water over the meat to defrost the meat. During interview on 03/16/22, at 9:06 a.m., R15 permitted her refrigerator to be opened. The refrigerator was small and had a separate freezer and refrigerator compartments. The freezer contained multiple packets of unlabeled and undated frozen items. The refrigerator was then opened and contained multiple undated food items. There were two plastic containers on the bottom of the refrigerator which had a red lid on each container. There were no dates written on the two plastic containers. R15 stated she purchased her own refrigerator and confirmed she prepared her own meals. R15 was asked if the facility staff ever provided her education on safety matters and food storage, R15 only stated she used microwavable utensils. R15 confirmed she would defrost her frozen meat products in the sink located in her bathroom and would run cold water over the meat. During interview on 03/16/22, at 11:36 a.m., regional sales and marketing (RSM)-CC and the director of nursing (DON) were present in R15's room. The DON stated she was not aware R15 prepared her own food and would defrost frozen meat items in her sink. During this interview a plastic container of rice and water was observed on the top of R15's refrigerator. The plastic container had a black top to secure the contents. The (RSM)-CC opened R15's refrigerator and confirmed there was a package of bacon, a variety of lunch meats and none of them had	F 813	Ongoing Monitoring: 5 weekly audits of resident rooms will be conducted to ensure personal food brought in by or for residents are handled and stored in accordance with facility policy. A summary of the audit results will be reviewed with the IDT at the monthly QAPI meeting for ongoing recommendations. Monitored By: DON/Designee	

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F 813	Continued From page 51 dates of when these items were opened. The (RSM)-CC confirmed there were two plastic containers at the bottom of the refrigerator with red lids. (RSM)-CC confirmed there were no dates on these containers. (RSM)-CC confirmed the refrigerator had a carton of unpasteurized eggs and the carton contained 10 brown eggs. The DON stated she was not aware R15 had a refrigerator in her room. (RSM)-CC confirmed one of the plastic containers had a chicken wing in it. During interview on 03/16/22, at 12:13 p.m., the administrator confirmed she was the head of housekeeping (H)-R and confirmed R15 defrosted her frozen meat in her sink located in the resident's bathroom. H-R confirmed she was unable to document the routine refrigerator temperatures since R15 did not have a thermometer in her refrigerator.	F 813		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain a quality assessment and assurance (QAA) committee that was effective in identifying and responding to quality deficiencies. This deficient practice had the potential to affect all 57 residents currently residing in the facility.	F 867	F867 QAPI/QAA IMPROVEMENT ACTIVITIES Immediate corrective action: A QAPI/QAA committee is scheduled for April 11, 2022. Corrective Action as it Applies to Others: At the next scheduled QAPI meeting, the	4/12/22

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F 867	Continued From page 52 Findings include: Quality tracking data was requested from the facility but was not received. Agendas for quality committee meetings 9/21-2/22 was requested but was not received. A review of attendance sheets for quality committee meetings from 9/21-2/22 showed: attendance for meetings in 9/21, 10/21, and 11/21. No attendance was provided for 12/21, 1/22, or 2/22. During an interview on 3/17/22, at 3:02 p.m. the director of nursing (DON) and assistant executive director (AED) were present. DON stated the facility quality committee had some recent changes due to a new medical director (MD). The MD has requested to lead the committee which was different than the model before lead by the administrator. The MD had their own process he wanted to follow, and the last meeting was about expectations and how to move forward. DON was not sure what the current focus of the committee was, but stated there had been work on hospitalizations, pest control, and indwelling catheters. Most of the monitoring included audits that were split between leaders. DON verified there was no system for communicating with staff but feel most of the concerns are brought from staff and staff were aware of what was being worked on. The AED stated many system issues were not currently being addressed, as most of the leadership team was new. AED verified the facility was aware of the quality control concerns and processes and with the new MD and leadership a good foundation was started. AED	F 867	IDT will review the process for quality data tracking, QAPI agenda development, and identification of issues with respect to quality assessment, quality assurance, and improvement activities. Ongoing, the QAPI committee will track, and record quality data based on facility indicators, review current quality improvement initiatives, and report, and collaborate on quality improvement opportunities. Prevent Recurrence: The policy for Quality Council-Quality Assurance and Performance was reviewed and remains current. The policy for Quality Council-Quality Assurance and Performance will be reviewed at the next QAPI meeting. Ongoing Monitoring: At the start of each QAPI council meeting the minutes from the previous meeting will be reviewed and accepted or amended based on the recommendations of the IDT. Quality council minutes will be logged and tracked to ensure an ongoing focus on quality improvement and performance activities. Monitored By: Executive Director	

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F 867	Continued From page 53 further stated the committee was in the process of rebuilding. A facility policy titled Quality Council- Quality Assurance and Performance Improvement Program revised 11/8/20, directed the facility to develop, implement, and maintain effective comprehensive and data driven QAPI program. The policy also directed the council meets monthly to identify issues with respect to quality assessment, quality assurance and improvement activities.	F 867		
F 926 SS=D	Smoking Policies CFR(s): 483.90(i)(5) §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, facility policy review, and review of U.S. Food and Drug Administration (FDA) warnings, the facility failed to develop and implement their smoking policies to include e-cigarettes to ensure a resident 1 of 5 residents (R-53) reviewed for smoking was assessed for the safe use of an e-cigarette. Specifically, R53 was permitted to charge and smoke (vape) his e-cigarette in the facility instead of being restricted to smoke/vape his e-cigarette in a designated smoking area. The facility policies failed to address the risks associated with charging e-cigarettes in resident rooms. The facility policies failed to address if a resident was to remain with the e-cigarette, in their room or on their person, the risks associated	F 926	F926 Smoking Policies Immediate corrective action: The e-cigarette for R53 is currently being stored by the facility, and R53 is informed of the designated smoking areas and the use of e-cigarettes in designated smoking areas only. Corrective Action as it Applies to Others: A review will be conducted to determine if other residents use e-cigarettes. E-cigarettes will be stored by the facility for resident□s use. Resident□s who use e-cigarettes will be informed of the use of e-cigarettes in designated smoking areas.	4/12/22

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F 926	Continued From page 54 with e-cigarette use, or if the device should be returned to staff after use. Findings include: Per U.S. Food & Drug Administration (FDA) "...What Else Can I Do?" Until all vapes and vape batteries conform to strong and consistent safety standards, your best protection against vape battery explosions may be knowing as much as possible about your device and how to properly handle and charge its batteries. Make sure you read and understand the manufacturer's recommendations for use and care of your device. If your vape did not come with instructions or you have further questions, contact the manufacturer. Don't remove or disable safety features-like fire button locks or vent holes-that are designed to prevent battery overheating and explosions. Only use batteries recommended for your device. Don't mix different brands of batteries, use batteries with different charge levels, or use old and new batteries together. Charge your vape on a clean, flat surface, away from anything that can easily catch fire and someplace you can clearly see it-not a couch or pillow where it is more prone to overheat or get turned on accidentally. Protect your vape from extreme temperatures by not leaving it in direct sunlight or in your car on a freezing cold night..." https://www.fda.gov/tobacco-products/products-ingredients-components/tips-help-avoid-vape-battery-explosions" Retrieved information on 02/15/22 Review of R53's electronic medical record (EMR) undated "Admission Record," located under the "Profile" tab, indicated R15 was admitted to the facility on 08/26/20.	F 926	Prevent Recurrence: The policy for Resident smoking will be revised to include the use of e-cigarettes in accordance with FDA recommendations. Staff will be educated on the policy. Ongoing Monitoring: Weekly audits will be conducted to ensure residents who use e-cigarettes have received education regarding the safe use of e-cigarettes in designated smoking areas. Monitored By: DON/Designee	

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Review of R53's EMR "Communication with Resident. . .Progress Notes," located under "Progress Notes" tab dated 09/11/21 indicated staff went over the smoking policy and informed the resident he could not smoke in the facility. The progress note indicated the smoking policy addressed the use of e-cigarettes. The progress note indicated R53 admitted he smoked an e-cigarette while in the facility.

Review of R53's EMR "Care Plan," located under "Care Plan" tab dated 09/13/21 indicated the resident was a current smoker, safe to smoke independently and revealed the resident may keep his smoking materials with him. The care plan indicated R53 required the supervision to smoke by staff. The care plan failed to address R53's use of e-cigarettes. The care plan directed staff to complete a smoking assessment, quarterly and as needed.

Review of R53's Minimum Data Set (MDS) with an Assessment Reference Period (ARD) of 02/24/22, indicated R53's Brief Interview for Mental Status (BIMS) score was 11 out of 15 which revealed the resident had moderate cognitive impairment.

Review of R53's EMR Smoking Evaluation Tool, located under "Assmnts" (Assessment) tab dated 03/02/22, determined R53 was safe to smoke. The prior "Smoking Evaluation Tool" was completed on 05/06/21.

During an interview on 03/15/22, at 8:23 a.m., R53 was observed to smoke from his e-cigarette and stated he charged the device in his room. The interview took place in a second floor visiting area, not in the designated smoking are outside.

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F 926	Continued From page 56 During an interview on 03/15/22, at 2:21 PM, activity director (AD)-B stated she took an e-cigarette from R53 and reported it to the administrator. AD-B did not provide a date when this incident occurred. During an interview on 03/16/22, at 5:38 p.m., nursing assistant (NA)-MM stated she saw the e-cigarette in R53's pocket of his coat and remembered reporting the incident to a pool nurse. NA-MM stated she did not remember who the staff member was she reported the e-cigarette to, nor did she remember when she found R53 with the e-cigarette. During an interview on 03/16/22, at 12:32 p.m., the administrator was asked what the difference was between a regular tobacco cigarette and an e-cigarette. The administrator was also asked if residents were permitted to smoke an e-cigarette in the facility and she stated she would need to investigate these issues since she did not smoke. The administrator did not provide a response to these questions before exiting the survey. Review of a policy provided by the facility titled "Smoking," dated May 2020, indicated ". . .Prior to or upon admission, the resident is made aware of the facility's smoking policy and procedures. . .If the facility allows smoking, there will be a designated areas for smoking that are posted. . .All residents who smoke will be assessed for their safety at time of admission/readmission, quarterly, and/or when there is a change in resident's condition. . ." The policy did not address e-cigarettes as the "Communication with Resident Progress Note" dated 09/11/21 indicated.	F 926		

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F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide a written notice of transfer/discharge for 2 of 2 residents (R22, R57) reviewed for hospitalizations.

Findings include:

R22's admission Minimum Data Set (MDS) dated 11/1/21, indicated R22 was cognitively intact and had diagnoses of cellulitis, lymphedema, and unspecified protein-calorie malnutrition.

R22's progress note dated 12/14/21, at 9:48 p.m. indicated R22 was taken to the hospital for evaluation of low blood pressure and diarrhea.

R22's medical record lacked evidence of a written transfer/discharge notification was provided.

During an interview on 3/17/22, at 9:31 p.m. the director of nursing (DON) stated a written bed hold and transfers was on the same form and should be given to residents when going to the hospital. Completed forms should be scanned into the medical record. The DON verified R22's medical record had no evidence a transfer notice was provided.

Facility policy titled Bed Hold and Re-Admission revised 5/20, directed before a resident was transferred to a hospital written notification was provided to the resident or representative that specifies the time and reason for transfer and the duration of the bed hold request.

Review of R57's "Progress Note" located in the electronic medical record (EMR) under the "Progress Notes" tab dated 1/11/22 and timed 10:30 a.m. revealed the resident reported to the staff that he fell to the floor and was able to get back into his bed. According to the note the resident complained of pain and was transferred to the hospital. Review of the medical record revealed he did not return to the facility.

The Resident's EMR was reviewed in its entirety and lacked indication a written discharge notice or evidence

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the ombudsman was notified of the discharge to the hospital.

On 3/17/22 at 9:58 a.m. Social Service Designee (SSD)-N stated she had not sent a discharge notice to the resident or the resident's representative and did not have any information related to a written discharge notice.

On 3/17/22 at 2:25 p.m. the director of nursing (DON) stated that she had no documentation to show a written discharge notice was issued or that the Ombudsman was notified of the discharge.

F 625

Notice of Bed Hold Policy Before/Upon Trnsfr
CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a written bed hold notice was provided to residents, and/or resident representatives, for 2 of 2 of residents (R22, R57) who were reviewed for hospitalizations.

Findings include:

R22's admission Minimum Data Set (MDS) dated 11/1/21, indicated R22 was cognitively intact and had diagnoses of cellulitis, lymphedema, and unspecified protein-calorie malnutrition.

R22's progress note dated 12/14/21, at 9:48 p.m. indicated R22 was taken to the hospital for evaluation of low blood pressure and diarrhea.

R22's medical record lacked evidence of a written bed hold notice was provided.

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During an interview on 3/17/22, at 9:31 p.m. the director of nursing (DON) stated written bed hold and transfers were on the same form and should be given to residents when going to the hospital. Completed forms then should be scanned into the medical record. The DON verified R22's medical record had no notice of a bed hold.

Facility policy titled Bed Hold and Re-Admission revised 5/20, directed before a resident was transferred to a hospital written notification was provided to the resident or representative that specifies the time and reason for transfer and the duration of the bed hold request.

Review of R57's "Progress Note" located in the electronic medical record (EMR) under the "Progress Notes" tab dated 1/11/22 and timed 10:30 a.m. revealed the resident reported to the staff that he fell to the floor and was able to get back into his bed. According to the note the resident complained of pain and was transferred to the hospital. Review of the medical record revealed he did not return to the facility.

The resident's EMR was reviewed in its entirety. There was no documentation in the EMR to prove the resident and/or the resident representative was given a written bed-hold notice.

On 3/17/22 at 2:25 p.m. the director of nursing (DON) stated that she had no documentation to show a written bed-hold notice was provided to the resident or resident representative.

On 3/17/22 at 9:58 a.m. social service designee (SSD)-N stated she did not send the resident or the resident's representative a bed hold notice and could not locate one.

Review of the facility policy titled "Bed Hold and Re-Admission" with a revision date of May 2020 stated, "Before a resident is transferred to a hospital or place on therapeutic leave, written notification is provided to the resident, and/or representative that specifies the duration of the bed hold period ..." The policy stated a copy of the notice/document would be placed in the resident's medical record.

F 641

Accuracy of Assessments
CFR(s): 483.20(g)

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure resident assessments accurately reflected a resident's status for 3 of 17 residents (R18, R42, R46) whom were reviewed.

Findings include:

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F 641	Continued From Page 4 Review R42's significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 2/15/22, located under the "MDS" tab in the electronic medical record (EMR) revealed Section N0350 A, insulin was coded with a seven, indicating he received insulin injections seven days prior to the ARD of 2/15/22. Review of the "Physician's Orders" and the "Medication Administration Record (MAR)" located under the "Orders" tab of the EMR revealed the resident did not have any orders for insulin and did not receive any insulin in the month of February 2022. On 3/17/22 at 12:24 p.m. R42's "MDS," "Orders", and "MAR" were reviewed with the director of nursing (DON). She verified the discrepancy and stated the resident was not on any insulin and stated it was coded in error. Review of R46's quarterly "MDS" with an ARD of 2/17/22 located in the "MDS" tab of the EMR was reviewed with the DON. The assessment was marked with a zero at section N0410, medications received. Review of the February 2022 "Physician's Orders" and the "MAR" located in the "Orders" tab revealed R46 received Eliquis(an anticoagulant), seven days prior to the date of the assessment. The DON verified the discrepancy and stated the resident did receive the Eliquis, but she was not sure if it counted as an anticoagulant. Review of R18's "MDS" with an ARD of 12/14/21 located under the "MDS" tab of the EMR with the DON. Review of Section O, Special Treatments, Procedures, and Programs revealed it was check marked at J to indicate the resident had received dialysis while a resident in the facility. The medical record and Physician Orders" were reviewed with DON. The orders and medical record lacked indication of the resident receiving dialysis while she was a resident in the facility. The DON stated the resident had not received dialysis and stated it was marked in error.
F 842	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;

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(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, nursing staff failed to accurately document in the Medication Administration Record (MAR) the days the resident was gotten up in a chair. This affected 1 of 17 (R1) sampled residents.

Findings include:

During observation on 03/14/22, at 2:32 p.m. revealed R12 was in bed. During interview at the same time, R12 stated staff was supposed to get him up and put him in his chair every morning and was he was supposed be up five to six hours per day, but they never get him up. He stated every time he asks to get up the staff tell

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him they do not have enough staff to get him up. He stated he was upset about not being assisted with getting up and even had a doctor's order to be gotten up in his chair every morning.

Review of R12's electronic medical record (EMR) under the "Medical Diagnosis" tab revealed his diagnoses included quadriplegia (paralysis of all four limbs), cerebral palsy, muscle weakness, and contracture of the joints.

Review of R12's "Physician's Orders" under the "Orders" tab in the EMR revealed a 01/26/22 physician order which read, "Ensure resident is up in w/c [wheelchair] every AM [morning]."

Observations and interview of R12 were completed on 03/14/22, from 12:15 p.m. through 7:07 p.m.; on 03/15/22, from 8:41 a.m. through 2:00 p.m.; on 03/16/22 from 5:24 a.m. through 3:30 p.m.; and on 03/17/22, from 9:01 a.m. through 1:01 p.m.. On 03/16/22, at 1:30 p.m. and on 03/17/22, at 9:01 a.m. and on 1:01 p.m. R12 stated no staff member had offered to get him up. When asked if he would get up if they offered, he stated yes and each time he stated he had a doctor's order to get up.

During interview on 03/17/22, at 9:08 a.m. nursing assistant (NA)-K stated he worked on 03/14/22, 03/15/22, and 03/16/22 on the unit R12 resided on. He verified the resident remained in bed during his 6:00 a.m. to 2:00 p.m. shift on 03/14/22, 03/15/22, and 03/16/22 and remained in bed as of 9:08 a.m. on 03/17/22. When asked why R12 was in bed and not gotten up he stated it was because they only had two aides to care for all the residents on the second floor and he did not have time.

Review of R12's MAR located in the "Orders" tab of the EMR revealed the nurse check marked that R12 was gotten up every day in March, including on 03/14/22, 03/15/22, 03/16/22, and 03/17/22. Registered nurse (RN)-Y initialed the MAR indicating R12 was gotten out of bed on 03/16/22 and 03/17/22. Interview on 03/17/22 at 1:15 p.m. RN-Y confirmed she had documented R12 was up in his chair on 03/16/22 and 03/17/22, however she did not see him up in his chair on those days. She said she had made a documentation mistake.

Interview on 03/17/22, at 10:13 a.m. the director of nursing (DON) revealed she also noticed the RN-Y was routinely documenting in the MAR that R12 was gotten out of bed and placed in the wheelchair when he had not been.

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HIGHLAND CHATEAU HEALTH CARE CENTER	**2319 WEST SEVENTH STREET** **SAINT PAUL, MN 55116**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/17/2022. At the time of this survey, Highland Chateau Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 04/07/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245028	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/17/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Highland Chateau Health Care Center, is a two-story building with a partial basement. The building was constructed at two different times. The original building was constructed in 1963 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the south side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as	K 000		

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K 000	Continued From page 2 one building The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
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 maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.3.1, and 14.4.5.3 through 14.4.5.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 345	K345 F Fire alarm system - Testing and maintenance Corrective Action □ Smoke detector sensitivity testing was completed. Identification of Other Residents □ All residents have the potential to be affected. Measures Put in Place Tasks have been created in TELS tasks	4/12/22

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K 345	Continued From page 3 On 03/1/2022 at 09:20 AM, it was revealed by a review of available documentation that there was no record of the last smoke detector sensitivity testing being completed. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 345	management system to ensure timely completion of tasks and required documentation is provided from the provider. Plant Operations staff have been educated on NFPA 101 (2012) Life Safety Code section 9.6.1.3. Monitoring Mechanisms Tasks will be audited monthly for next 3 months to ensure compliance with testing requirements and report results to QAPI.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/17/2022 at 9:30 AM, it was revealed by a review of available documentation that the facility does not have a current out of service policy for	K 346	K346 F Fire alarm system - Out of Services Corrective Action □ The Life Safety book was reviewed and updated. The Fire Protection Systems Out of Service policy was updated and addresses the out of service policy for the fire alarm system. Identification of Other Residents □ All residents have the potential to be affected.	4/12/22

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K 346	Continued From page 4 the fire alarm system. An interview with the Facility Director verified this deficiency finding at the time of discovery.	K 346	Measures Put in Place □ Review of the Life Safety book at QAPI committee at a minimum annually. Executive Director and Plant Operations staff have been educated on the policy and procedure. Monitoring Mechanisms □ QAPI Committee will review monthly x 3 months then annually after that.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic fire sprinkler system per NFPA 101	K 353	K353 F Sprinkler System - Maintenance and testing	4/12/22

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K 353	Continued From page 5 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/17/2022 at 9:10 AM, it was revealed by a review of available documentation that the facility did not have a copy of their annual fire sprinkler system report in their life safety book. An interview with the Facility Director verified this deficiency finding at the time of discovery.	K 353	Corrective Action □ Annual fire sprinkler system testing was completed. The Fire Sprinkler system report is included in the Life Safety book. Identification of Other Residents □ All residents have the potential to be affected. Measures Put in Place Tasks have been created in TELS tasks management system to ensure timely completion of tasks and required documentation is provided from the provider. Plant Operations staff have been educated on NFPA 101 (2012) Life Safety Code section 9.6.1.3. Monitoring Mechanisms Tasks will be audited monthly for next 3 months to ensure compliance with testing requirements and report results to QAPI.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler	K 354		4/12/22

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K 354	Continued From page 6 system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.2.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement an automatic fire sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.7.6 and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Chapter 15. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/17/2022 at 9:40 AM, it was revealed by a review of available documentation that the facility did not have a current fire sprinkler system out of service policy. An interview with the Facility Director verified this deficiency finding at the time of discovery.	K 354	K354 F Sprinkler System - Out of Service Corrective Action □ The Life Safety book was reviewed and updated on 4/6/2022. The Fire Protection Systems Out of Service policy was updated and addresses the fire sprinkler system out of service policy. Identification of Other Residents □ All residents have the potential to be affected. Measures Put in Place □ Review of the Life Safety book at QAPI committee at a minimum annually. Executive Director and Plant Operations staff have been educated on the policy and procedure. Monitoring Mechanisms □ QAPI Committee will review monthly x 3 months then annually after that.	
K 781 SS=C	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	K 781		4/12/22

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K 781	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a policy prohibiting portable space heaters per NFPA 101 (2012 edition), Life Safety Code, section 19.7.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/17/2022 at 10:00 AM, it was revealed by a review of available documentation that the facility does not have a current policy prohibiting the use of portable space heaters in non-staff areas. An interview with the Facility Director verified this deficient finding at the time of discovery.	K 781	K781 C Portable Space Heaters Corrective Action □ The Life Safety book was reviewed and updated. The Space Heater policy was updated and addresses prohibiting the use of portable space heaters in non-staff areas. Identification of Other Residents □ All residents have the potential to be affected. Measures Put in Place □ Review of Life Safety book at QAPI committee at a minimum annually. Executive Director and Plant Operations staff have been educated on the policy and procedure. Monitoring Mechanisms □ QAPI Committee will review monthly x 3 months then annually after that.	
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	K 914		4/12/22

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K 914	Continued From page 8 intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect electrical receptacles per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/17/2022 at 10:10 AM, it was revealed by a review of available documentation that the facility has not completed electrical outlet testing at resident bed locations. The last available test was dated 2020. An interview with the Facility Director verified this deficiency finding at the time of discovery.	K 914	K914 F Electrical Systems - Maintenance and testing Corrective Action □ Electric outlet testing at resident bed locations was completed. Identification of Other Residents □ All residents have the potential to be affected. Measures Put in Place □ The Plant Operations staff was educated on the policy and procedure for testing of non-hospital grade receptacles of resident bed locations. Monitoring Mechanisms □ Testing records will be audited monthly for next 3 months to ensure compliance with testing requirements and report results to QAPI.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		4/12/22

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K 920	Continued From page 9 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain relocatable power taps per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/17/2022 at 11:00 AM, it was revealed by observation that there were several devices plugged into a non-UL 1363 listed power tap in	K 920	K920 D Electrical Equipment - Power Cords and Extensions Corrective Action □ An audit was completed to ensure no non-UL 1363 listed power taps were in resident rooms. Identification of Other Residents □ All residents have the potential to be affected.	

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K 920	Continued From page 10 Room 222. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 920	Measures Put in Place □ All staff were educated on the facility□s procedure for power cords and extensions located within the facility. Monitoring Mechanisms □ Education will be audited weekly for 3 weeks to ensure education is completed.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 2, 2022

CMS Certification Number (CCN): 245028

Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

Dear Administrator:

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

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

Effective April 12, 2022 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 2, 2022

Administrator
Highland Chateau Health Care Center
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: March 4, 2022

Dear Administrator:

On March 16, 2022, we notified you a remedy was imposed. On April 19, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 12, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 31, 2022 be discontinued as of April 12, 2022. (42 CFR 488.417 (b))

In our letter of March 16, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 31, 2022. 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,

Kamala Fiske-Downing

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