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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TVJH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00073

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245499**
2.STATE VENDOR OR MEDICAID NO.
(L2) **190176100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CALEDONIA REHABILITATION & RETIREMENT CENTER**
(L4) **425 NORTH BADGER STREET**
(L5) **CALEDONIA, MN** (L6) **55921**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2018**

6. DATE OF SURVEY **02/26/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Krebs, HFE NE II 04/23/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 04/27/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/27/2021
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 19, 2021

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

RE: CCN: 245499
Cycle Start Date: February 26, 2021

Dear Administrator:

On February 26, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 18, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 18, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 18, 2021.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by April 18, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Caledonia Rehabilitation & Retirement Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 18, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 August 26, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	C 02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA REHABILITATION & RETIREMENT CENTER	**425 NORTH BADGER STREET CALEDONIA, MN 55921**

(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 with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 2/25/2021 , during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain	E 004		4/14/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/27/2021

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

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E 004	Continued From page 1 an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to review the Emergency Operations Plan (EOP) annually in accordance with the requirements of CFR 483.73. This had the potential to affect all 34 residents currently residing in the facility. Findings include: The facility EOP page ii indicated, "This document is Caledonia Rehabilitation and Retirement's Emergency Operations Plan (EOP) and states our understanding of how we manage and conduct actions under emergency conditions. It will be reviewed and updated if necessary, on an annual basis. This EOP has been reviewed and approved by our organization's leadership." The reviewed and approved date was 7/26/19. During interview on 2/25/21, at 9:53 a.m. the administrator verified the facility had not performed and documented a review of the EOP in the last year with the exception of updating the administration which had been done after the survey started.	E 004	-The Facility's emergency preparedness plan was reviewed and documented -Residents and staff have the ability to be affected if the emergency preparedness plan is not reviewed and documented in accordance to requirements. -Staff educated on the importance of reviewing and documenting the review of the emergency preparedness plan -1x/quarter audit for 12 months on the emergency preparedness plan will be completed to ensure a documented review is present. -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -NHA/Designee is responsible -Corrective action completed by 4/14/21	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3)	E 007		4/14/21

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E 007	Continued From page 2 [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address their resident population including the persons at risk in their emergency preparedness plan. This had the potential to affect all 34 residents residing at the facility. Findings include: During interview on 2/25/21, at 9:54 a.m. the	E 007	-The Facility's emergency preparedness plan addresses the resident population served, including those at risk -Residents, including those at risk, have the ability to be affected if the emergency preparedness program does not address the population. -Staff educated on the importance of addressing the resident population within	

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E 007	Continued From page 3 administrator verified the facility emergency plan did not address the population of persons served.	E 007	the Facility's emergency preparedness plan -1x/quarter audit for 12 months on the emergency preparedness plan will be completed to ensure the resident population is addressed within the program. -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -NHA/Designee is responsible -Corrective action completed by 4/14/21	
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies	E 013		4/14/21

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E 013	Continued From page 4 and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to review policies and procedures for hazards deemed significant based on the facility's all hazards risk assessment as part of their emergency preparedness plan on an annual basis in accordance with the requirements of CFR 483.73(a)(1)(2). This deficient practice could affect all 34 residents of the facility. Findings include: During interview on 2/25/21, at 9:57 a.m. the administrator verified the facility failed to review and update the policies and procedure on an annual basis. The administrator verified the last review was completed in 2019.	E 013	-The Facility's EP Policies and Procedures for hazards deemed significant were reviewed -Residents have the ability to be affected if policies and procedures related to hazards deemed significant are not reviewed at least annually -Staff educated on the importance of reviewing EP policies and procedures for most accurate record and programming -1x/quarter audit for 12 months on the EP program will be completed to ensure policies and procedures are reviewed and current -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -NHA/Designee is responsible -Corrective action completed by 4/14/21	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the	E 015		4/14/21

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E 015	Continued From page 5 emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following:	E 015		

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E 015	Continued From page 6 (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include in their emergency operations plan (EOP) how to obtain pharmaceutical supplies and how to maintain sewage and waste disposal during an emergency. This had the potential to affect 34 residents at the facility. Findings include: Review of the facility's EOP reviewed 7/26/19, the facility failed to address how they would obtain pharmaceutical supplies and how they would maintain sewage and waste disposal during an emergency. During interview on 2/25/21, at 10:00 a.m., the administrator verified this information.	E 015	-The Facility's EP plan includes how to obtain pharmaceutical supplies and how to maintain sewage and waste disposal during an emergency. -Residents and staff have the ability to be affected if needs of pharmacy supplies, sewage, and waste disposal are not addressed with in the EP Plan -Staff educated on the importance of proactively planning for the subsistence needs for staff and residents and where the plans can be located within the EP Plan. -1x/quarter audit for 12 months on the EP program will be completed to ensure subsistence needs for residents and staff is present. -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -NHA/Designee is responsible -Corrective action completed by 4/14/21	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this	E 023		4/14/21

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E 023	Continued From page 7 section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy and procedure for preservation of medical documents. This had the potential to affect all 34 residents residing in the facility. Findings include: The facility's emergency operations plan	E 023	-The Facility possesses a policy and procedure addressing the preservation of medical documents. -Residents have the ability to be affected if the facility does not have a preservation of medical documents policy and procedure within the EP program -Staff educated on the importance of having a policy and procedure addressing	

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E 023	Continued From page 8 reviewed 7/26/19, was reviewed with the administrator. The facility had no system in place that would preserve patient information, protect confidentiality of patient information, and secure and maintain availability of records in the event of an emergency. During an interview on 2/25/21, at 10:03 a.m. the administrator verified there was not a policy or procedure to preserve medical documents.	E 023	the preservation of patient information, protect confidentiality of patient information, and secure and maintain availability of records in the event of an emergency. -1x/quarter audit for 12 months on the EP program will be completed to ensure the Preservation of Medical Documents Policy and Procedure is within the Facility's EP Plan. -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -NHA/Designee is responsible -Corrective action completed by 4/14/21	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and	E 026		4/14/21

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E 026	Continued From page 9 procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop policies and procedures in its emergency plan describing the facility's role in providing care and treatment at alternate care sites under section 1135 act waiver. This had the potential to affect all 34 residents currently residing in the facility. Findings Include: The facility emergency operations plan reviewed did not contain information of a policy describing the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. During an interview on 2/25/21, at 10:06 a.m. the administrator confirmed the lack of a policy and procedure, which specifically identified the facility's role in providing care and treatment at alternate care sites under an 1135 waiver.	E 026	-The Facility possesses a policy and procedure addressing the Facility□s role in providing care and treatment at alternative care sites under an 1135 waiver. -Residents have the ability to be affected if required policies and procedures are not included in the facility□s EP plan -Staff educated on the importance of a comprehensive and compliant EP plan including the need for a policy and procedure regarding the facility□s role in providing care and treatment at an alternative site under an 1135 waiver. -1x/quarter audit for 12 months on the EP plan will be completed to ensure the Facility□s Role/1135 Waiver Policy and Procedure is within the Facility□s EP Plan. -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -NHA/Designee is responsible -Corrective action completed by 4/14/21	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every	E 030		4/14/21

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E 030	Continued From page 10 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the	E 030		

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E 030	Continued From page 11 following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the	E 030		

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E 030	Continued From page 12 OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's communication plan failed to include the required information including facility staff names and contact numbers and names and contact information for physicians. This had the potential to affect all 34 residents in the facility. Findings include: During interview on 2/25/21, at 10:10 a.m. the administrator acknowledged the was no list of physicians and their contact numbers or staff names and their contact numbers information in the emergency preparedness plan.	E 030	-The Facility's EP communication plan includes the required information including facility staff names and contact numbers, and contact information for physicians. -Residents have the ability to be affected if the EP communication plan does not include staff and physician contact numbers and information -Staff educated on the importance of having staff and physician contacts, numbers, and information within the facility's EP plan -1x/quarter audit for 12 months on the facility's EP communication plan will be completed to ensure the contact list and information is present and accurate. -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -NHA/Designee is responsible -Corrective action completed by 4/14/21	
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff.	E 031		4/14/21

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E 031	Continued From page 13 (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policy and procedure which included contact information for the Ombudsman. This had the potential to affect all 34 residents who currently resided in the facility. Findings include: During an interview on 2/25/21, at 10:38 a.m. the facility's Emergency Operations Plan was reviewed the administrator who confirmed the findings. The plan included components of an emergency preparedness communication plan, however, lacked documentation of contact information for the Ombudsman.	E 031	-The Facility's EP includes documentation of contact information for the Ombudsman -Residents have the ability to be affected if the Facility's EP plan does not include documentation of contact information for the Resident's Ombudsman -Staff educated on the importance for a comprehensive and compliant EP program including the contact information for the Ombudsman -1x/quarter audit for 12 months on the facility's EP plan will be completed to ensure the contact information for the Ombudsman is documented within and	

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E 031	Continued From page 14	E 031	accurate. -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -NHA/Designee is responsible -Corrective action completed by 4/14/21	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal	E 033		4/14/21

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E 033	Continued From page 15 representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Operations Plan (EOP) included a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care. This had the potential to affect all 34 residents at the facility. Findings include: The facility's EOP plan reviewed 7/26/19, lacked a policy and procedure that addressed how the facility would share information with outside resources during an emergency. During an interview on 2/25/21, at 10:20 a.m. the administrator confirmed the facility had not developed policies and procedures related to sharing information with outside resources during an emergency.	E 033	-The Facility's EP Plan includes a policy and procedure addressing how the Facility would share information with outside resources during an emergency. -Residents have the ability to be affected if the facility does not have a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care. -Staff members educated on the importance of a comprehensive and complaint EP program including the need for an information sharing to outside organizations during an emergency policy and procedure -1x/quarter audit for 12 months on the facility's EP plan will be completed to ensure the Policy and Procedure addressing information sharing with outside resources during an emergency is present and accurate. -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -NHA/Designee is responsible -Corrective action completed by 4/14/21	
E 035	LTC and ICF/IID Sharing Plan with Patients	E 035		4/14/21

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E 035 SS=C	Continued From page 16 CFR(s): 483.73(c)(8) *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years.] The communication plan must include all of the following: *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Emergency Operations Plan (EOP) was communicated to residents and/or representatives. This had the potential to affect all 34 residents who resided at the facility. Findings include: The facility's EOP plan reviewed 7/26/19, lacked documentation of a method for sharing information from the emergency plan the facility had determined appropriate with residents and their families or representatives.	E 035	-Emergency Preparedness Information was shared with our existing residents and their families/representatives. Emergency Preparedness information was made a part of new admission paperwork -Residents/their families/representatives have the ability to be affected if EP information is not shared. -Staff educated on importance and expectation for EP information to be shared with residents/families/ representatives -2x/week audit for 1 month on new	

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E 035	Continued From page 17 During an interview on 2/25/21, at 11:56 a.m. the administrator confirmed the facility had not developed a method for sharing information from the emergency plan with residents and their families.	E 035	admission paperwork will be completed to ensure emergency preparedness information is shared with residents and/or their families or representatives. -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -Admissions Coordinator/Designee is responsible -Corrective action completed by 4/14/21	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness	E 037		4/14/21

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E 037	Continued From page 18 policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 19 *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 20 *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct training upon hire of the	E 037	-EP Training and Risk Assessment is a part of general new hire orientation	

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E 037	Continued From page 21 emergency operations plan (EOP) plan with staff. This had the potential to affect all 34 residents and staff. Findings include: During an interview on 2/25/21, at 10:31 a.m. human resources confirmed EOP training was completed on an annual basis however, lacked documentation to indicate the facility had training upon hire based on the emergency plan and risk assessment completed by the facility.	E 037	-Staff and residents have the ability to be affected if EP training does not occur upon hire -Staff educated on the key elements and policies/procedures, of the Facility's EP program. New Hire Orientation includes EP training and Risk Assessment. -2x/week audit for 1 month on new hire orientation will be completed to ensure emergency plan and risk assessment training is present. -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -HR/Designee is responsible -Corrective action completed by 4/14/21	
F 000	INITIAL COMMENTS On 2/22/21, through 2/26/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found 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: H5499044C (MN63661) The following complaints were found to be SUBSTANTIATED with no deficiency: H5499042C (MN62507) H5499043C (MN69239) The following complaints were found to be SUBSTANTIATED with deficiencies: H5499040C (MN56088), citation issued at F689	F 000		

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F 000	Continued From page 22 H5499041C (MN62263), citations issued at F623, F625, and F880 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that	F 567		4/14/21

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F 567	Continued From page 23 is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to keep an accounting of money in the resident funds accounts and failed to keep any resident fund money in an interest-bearing account. This had the potential to affect all 12 residents that had money in a personal fund account with the facility. Findings include: During an interview on 02/25/21, at 12:25 p.m. the administrator and business office manager (BOM) stated 12 current resident had trust accounts and the facility was unable to determine at this time how much money was in each resident account. The BOM stated she was planning to go to the bank to get the deposit slips	F 567	-Resident funds and records are up-to-date and accurate. Resident funds are in an interest-bearing account. -Residents with personal trust funds have the ability to be affected if accounting and records are not current and accurate or within an interest-bearing account. -BOM Staff Member educated on importance of current and accurate resident personal funds and need for an interest-bearing account. A new bank account that is an interest-bearing account was established and Resident Funds are appropriately within. The facility created a spreadsheet of Resident Accounts that is currently being maintained. The facility utilizes Point Click	

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F 567	Continued From page 24 to figure out how much money was in each account from the bank documentation of deposits. The BOM stated the resident funds were kept in a checking account rather than a saving account. The BOM stated the bank was going to work with her to get money transferred into an interest-bearing account and stated she talked to the bank about that this afternoon. A policy on personal funds accounts was requested and not provided. Review of the facility's "Combined Federal and State Bill of Rights [given to the residents and resident representatives during admission]" with the last revision on 11/28/16 revealed under "Self-Determination" "...Deposit of funds...a. The facility must deposit any residents' personal funds in excess of $100 in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) ...b. Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50. In an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)."	F 567	Care and will be utilizing the 'Admin' Tab for Trust Accounts once the PCC Admin Tab goes live. BOM was educated on the policy and expectation of Resident Accounting and Records to mitigate future citation. -1x/week audit for 2 months on personal funds will be completed to ensure accounting and records are current and accurate -Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -BOM/Designee is responsible -Corrective action completed by 4/14/21	
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a	F 568		4/14/21

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F 568	Continued From page 25 system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide quarterly statements for resident fund accounts for 4 of 4 residents (R10, R12, R28, R138) reviewed. In addition, the facility failed to maintain a separate accounting of each resident's funds and failed to follow accounting principles for the accounts. This affected all 12 residents who had resident fund accounts overseen by the facility. Findings include: During an interview on 2/22/21, at 6:51 p.m. R10 stated they had not received a quarterly statement from the facility. During an interview on 02/25/21, at 11:21 a.m. the business office manager (BOM) stated R10 had a personal trust account with the facility and indicated R10 was admitted 7/2/2020. The BOM stated the personal funds statements were to be sent out on a quarterly statement. The BOM stated the previous BOM's last day at the facility was the 1/16/21 and indicated she had been unable to determine the last time the previous	F 568	-Quarterly Trust Statements were issued to Residents/Responsible Parties with fund accounts overseen by the facility. Separate accounting records are present for each Resident with fund accounts overseen by the facility. -Residents with trust accounts have the potential to be affected if quarterly statements are not issued or if resident's accounting records are not separate. -BOM Staff Member educated on the need for quarterly trust statements to be issued and the expectation that Resident fund accounts are separate and maintained. The facility created a spreadsheet of Resident Accounts that is individual currently being maintained. The facility utilizes Point Click Care and will be utilizing the 'Admin' Tab for Trust Accounts once the PCC Admin Tab goes live. BOM was educated on the policy and expectation of Resident Accounting and Records/Quarterly Statements to mitigate future citation. -1x/month audit for 12 months on resident	

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F 568	Continued From page 26 BOM had sent out quarterly statements. During an interview on 02/25/21, at 12:25 p.m. the administrator and BOM stated they identified last week quarterly statements were not being sent to residents. The administrator and BOM stated the previous person had indicated they were behind on sending out quarterly statements and stated they had been unable to find any records of when last quarterly statements were sent out to residents. The BOM stated 12 current resident had trust accounts and the facility was unable to determine at this time how much money was in each resident account. The BOM stated she was planning to go to the bank to get the deposit slips to figure out how much money was in each account from the bank documentation of deposits. The BOM stated the resident funds were kept in a checking account rather than a saving account. The BOM stated the bank was going to work with her to get money transferred into an interest- bearing account and stated she talked to the bank about that this afternoon. A policy on personal funds accounts was requested and not provided.	F 568	trust statements and Resident Accounts will be completed to ensure statements are being issued at least quarterly and accounts are separate and maintained. -Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -BOM/Designee is responsible -Corrective action completed by 4/14/21	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		4/14/21

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F 580	Continued From page 27 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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F 580	Continued From page 28 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of a shoulder injury following a near miss fall from the standing lift for 1 of 3 residents (R23) reviewed for accidents. Findings include: R23's quarterly Minimum Data Set (MDS) assessment, dated 1/5/21, indicated the resident had moderately impaired cognition and required extensive assistance with bed mobility, transfers, toilet use, personal hygiene, dressing, and locomotion on the unit. The MDS further identified a diagnosis of end stage renal disease (ESRD), and received dialysis services. R23's care plan, indicated the resident required extensive assistance from one staff with the EZ stand (mechanical machine). R23's current physician orders included: Lortab tablet (a narcotic medication) 5-325 mg (milligrams) give one tablet by mouth every 8 hours as needed for pain. R23's nursing progress note dated 1/30/21 at 5:20 p.m. indicated: Upon arrival from dialysis, resident pulled her call light. CNA (certified nursing assistant) went to room 204, resident asked to use the commode. CNA was trying to use the easy stand to get her on the commode, while getting her off the commode she started to slide out because the sling that was used was not the actual size. Resident was lowered to the	F 580	1. Immediate action(s) taken for the resident(s) found to have been affected include: R23 Physician Notified 3/2/21. No change in order by the physician. 2. Identification of other residents having the potential to be affected was accomplished by: Residents records audit for the past 30 days. 6 residents had falls and potential to be affected physician was notified and physician orders followed as indicated. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed nursing staff will be in serviced on physician notification process related to change of condition r/t to a fall or near miss fall, the expectation to notify the MD by telephone or email (this is in the resident chart) by April 14, 2021. Licensed nursing staff hired after April 14-2021 will be in serviced during orientation on this process. The facility now places significant changes r/t to falls or near misses' notifications on the 24-hour report. DON/Designee will review residents charting in morning clinical meeting for documented MD notification. 4. How the corrective action(s) will be	

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F 580	Continued From page 29 floor and called for help. She was assisted off the floor into there bed. Denied injury. R23's nursing progress note dated 1/30/21 at 8:34 p.m. indicated: Resident requested pain medication, Lortab tablet 10-325 mg administered for shoulder pain 6/10 (rated 6 out of 10). R23's Occupational Therapy Treatment Encounter Note dated 2/1/21 included: Reviewed resident's fall over the weekend - was lowered to the floor from the EZ stand during a transfer after her dialysis, reports was dizzy, feels she passed out, is now having left shoulder and neck pain, 0/10 at rest but 4/10 with any AROM (active range of motion) and resistive use; muscle knot left shoulder. R23's nursing progress note dated 2/2/21, at 5:08 a.m. indicated the resident received a dose of her as needed Lortab pain medication for complaints of pain in both shoulders. Further review of R23's medication administration record (MAR) dated 2/1/21 - 2/28/21, indicated R23 received the Lortab on 2/2/21 for pain rated 8/10, 2/3/21 (pain not rated), 2/5/21 for pain rated 6/10, 2/7/21 for pained rated 5/10, and 2/8/21 for pain rated 5/10. Further review of R23's medical record did not include evidence the physician was notified of the resident's complaints of shoulder pain following the incident on 1/30/21, when R23 was lowered to the floor. When interviewed on 2/24/21, at 4:49 p.m. R23 stated approximately one month ago she had	F 580	monitored to ensure the practice will not recur: DON or designee will audit for MD change of condition r/t falls or near miss falls documented notification 2x/week for one month then 1 x wk for two months. Results of finding will be reviewed in QAPI monthly to validate compliance after 3 months. Corrective action completion date: ____04/14/2021_____.	

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	245499	A. BUILDING _____ B. WING _____	C 02/26/2021

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F 580	Continued From page 30	F 580		

returned from dialysis and after using the commode while being transferred to bed, felt light-headed and must have fainted. R23 stated when this happened the sling pulled up around her shoulders causing her arms to go up. R23 confirmed her shoulders didn't hurt at first but did the next morning and for several days afterwards. R23 stated she couldn't do a lot in therapy because her shoulders and neck muscles were so sore, and stated, "I could hardly move my arms". R23 further stated the occupational therapist (OT)had put warm packs on her neck; it was starting to worry R23 because the pain continued for a few days, and when yawning her neck muscles would hurt. R23 was surprised they didn't want to x-ray her shoulder. R23 confirmed she would let the nursing staff know about the shoulder pain and they would offer her Tylenol. When staff would get her out of bed the pain was excruciating and for a while it took 2 staff to get her up. R23 stated she still could feel a little soreness but was almost back to baseline.

When interviewed on 2/25/21, at 4:49 p.m. registered nurse (RN)-A stated she couldn't remember if the physician had been notified during rounds about R23's shoulder pain. RN-A reviewed when the last physician rounds occurred and verified it was on 1/23/21, which was prior to R23's incident on 1/30/21. RN-A confirmed she had not called the physician related to R23's c/o shoulder pain following the incident on 1/30/21 when R23 was lowered to the floor.

A policy on notification to physician was requested but not received.

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F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		4/14/21

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F 584	Continued From page 32 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide a homelike environment during dining to 1 of 1 of residents (R13) who was observed eating from breakfast from a Styrofoam container. Findings include During an observation and interview on 2/23/2021, at 11:35 a.m. R13 sat in his wheelchair in his room, the right side of his wheel chair had an attached arm rest with a divided Styrofoam container containing sausage links. An unidentified dietary aide (DA) was in R13's room inquiring what he would like for lunch. DA stated residents were served breakfast in the Styrofoam but did not know why. R13's nutritional care plan dated 12/1/2020, included honor resident food preferences, provide adaptive equipment as needed: large handled silverware. R13's activities of daily living care plan dated 9/6/2019, for eating included provide finger food when the resident has difficulty using utensils. During an interview on 2/23/2021, at 4:36 p.m. R13 was sitting up in his wheelchair in his room. R13 stated he did not like eating out of the Styrofoam containers and would prefer not to. R13 stated sometimes it was difficult to eat from them.	F 584	-R13 was interviewed regarding plate ware preference and his preferences are being honored. -Residents have the ability to be affected if their plate wear preferences are not supported -Multidisciplinary Staff educated on the importance of asking and upholding resident preferences in line with person-centered care. In house Residents were offered to fill out a Resident Preferences sheet for their records. The Resident Preferences document is to be incorporated into initial care conferences to capture Resident Centered Care preferences. -2x/week audits for 2 months on Resident preferences will be completed to ensure resident centered care that emphasizes comfort, independence, personal needs, and preferences is honored -Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation -Social Services/Designee is responsible -Corrective action completed by 4/14/21	

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F 584	Continued From page 33 During an observation and interview on 2/24/2021, at 7:12 a.m. R13 sat up in his chair in his room, certified dietary manager (CDM) delivered R13's breakfast to him in a Styrofoam container. CDM stated that the previous dietary manager had started using Styrofoam containers because of COVID-19; there wasn't a lot of time between breakfast and lunch to clean the dinnerware. Facility policy Quality of Life-Homelike environment dated 2/2014, included: 1) Staff shall provide person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. 3) The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting.	F 584		
F 623 SS=D	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	F 623		4/14/21

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F 623	Continued From page 34 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	F 623		

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F 623	Continued From page 35 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 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).	F 623		

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F 623	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide written hospital transfer notices to the resident(s) and/or resident's representative who had a facility-initiated transfer and failed to accurately notify the Office of the State Long-Term Care Ombudsman (OMB) of hospital transfers for 2 of 2 resident (R136, R2) reviewed for hospitalizations. Findings include: R136's progress notes dated 5/19/2020, at 9:47 a.m. included, "Resident hollering out from her room; call light within easy reach. Resident teary eyed and self reports not being able to walk by herself. Extensive assistance of 2 staff to transfer into from chair into wheelchair and from chair onto toilet with gait belt. Temp [Temperature] 98.0, [pulse] 82, [respirations] 16, [blood pressure]112/80. Lungs clear, offers no complaints of pain. Color pink, oxygen 1L [liter] 85% sats [saturations] via nasal cannula. Resident states she would like to be seen in ED [emergency department]. Call out to [certified nurse practitioner CNP-A]. R136's progress note dated 5/19/2020, at 10:21 a.m. included, "[CNP-A] returned call; to send to ED [emergency department] via ambulance d/t [due to] change of condition. Ambulance took resident to ED [emergency department]." R136's progress note dated 5/19/2020, at 4:42 p.m. included, "After resident sent to ED [emergency department], this nurse tried calling family, did not leave a message due to phone	F 623	1. Immediate action(s) taken for the resident(s) found to have been affected include: R136 has since discharged from the facility on 5/19/20. R2 was transferred from MD appt to hospital on 3/8/21. Resident returned to facility on 3/15/21. Ombudsman notified via email on 3/24/21. 2. Identification of other residents having the potential to be affected was accomplished by: Audit completed of current residents for past 30 days for validation of transfer of hospital/discharge for ombudsman notification. One other resident had potential for being affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: DON in service on 3/24/21 via zoom with clinical consultant on ombudsman discharge/transfer notification. DON contact Ombudsman on 3/11/21 for his preferred method of contact and frequency. New Social worker will be in serviced during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON or designee will audit for Ombudsman notification of transfers or discharges for 2/week for one month then	

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F 623	Continued From page 37 number a business. [medical doctor MD-A] is going to try calling family change of condition. Ambulance took resident to ED [emergency department]." R136's medical record lacked evidence of notification and/or reason regarding transfer, the statement of the residents' appeal rights or information on how an appeal form was obtained, and it lacked the contact information of the Office of the States Long-Term Care Ombudsman. During an interview on 2/24/21, at 8:10 a.m. the director of nursing (DON) stated she did not see documentation of reason for transfer to the resident/resident representative or notification of the ombudsman of R136's hospitalization in her medical record. The DON stated she was not aware the ombudsman notification of a resident's hospitalization needed to be done. During an interview on 2/26/21, at 9:26 a.m. registered nurse (RN)-A stated she was not aware the ombudsman needed to be notified of resident hospitalizations. R2's progress note dated 12/21/2020, at 4:34 p.m. included, "received call from wife stating resident is to be sent to [name of hospital] ED [emergency department]. Resident in agreeance. NP updated." R2's medical record lacked evidence the Office of the State's Long-Term Care Ombudsman was notified of the transfer. R2's progress note dated 1/25/2021, at 10:20 a.m. included, "Resident request to be sent to ED. c/o [complained of shortness of breath." The	F 623	1 x wk for two months. Results of finding will be reviewed in QAPI monthly to validate compliance after 3 months.	

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F 623	Continued From page 38 note indicated the physician was updated. R2's medical record lacked evidence of notification and/or reason regarding transfer, the statement of the residents' appeal rights or information on how an appeal form was obtained, and it lacked notification to the State's Long Term Care Ombudsman. During an interview on 2/26/2021, at 2:00 p.m. director of nursing (DON) stated she did not see documentation of the statement of resident's appeal right or information on how to appeal form was obtained, and it lacked the contact information of the Office of the States Long-Term Care Ombudsman. The Transfer and Discharge (including AMA [against medical advice]) policy dated 2020 included, "Provide a transfer notice as soon as practicable to resident and representative. Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list."	F 623		
F 625 SS=D	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	F 625		4/14/21

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F 625	Continued From page 39 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 document review and interview, the facility failed to provide written bed hold notice to residents or resident representatives at the time of transfer, or in cases of emergency transfer, within 24 hours, that specified policies regarding bed hold, and the reserve bed payment. This had the potential to affect 2 of 2 residents (R136, R2) reviewed for hospitalization. Findings include: R136's progress notes dated 5/19/2020, at 9:47 a.m. included, "Resident hollering out from her room; call light within easy reach. Resident teary eyed and self reports not being able to walk by herself. Extensive assistance of 2 staff to transfer into from chair into wheelchair and from chair onto toilet with gait belt. Temp [Temperature] 98.0, [pulse] 82, [respirations] 16, [blood	F 625	1. Immediate action(s) taken for the resident(s) found to have been affected include: R139 care plan was updated 2/26/21 for at risk for abnormal bleeding, spontaneous bleeding, potential hemorrhage and/or increased/easy bruising r/t taking anticoagulant. 2. Identification of other residents having the potential to be affected was accomplished by: Current resident records audit for the past 30 days to ensure that a comprehensive care plan was implemented with all required elements of the individual resident needs. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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F 625	Continued From page 40 pressure]112/80. Lungs clear, offers no complaints of pain. Color pink, oxygen 1L [liter] 85% sats [saturations] via nasal cannula. Resident states she would like to be seen in ED [emergency department]. Call out to [certified nurse practitioner CNP-A]. R136's progress note dated 5/19/2020, at 10:21 a.m. included, "[CNP-A] returned call; to send to ED [emergency department] via ambulance d/t [due to] change of condition. Ambulance took resident to ED [emergency department]." R136's progress note dated 5/19/2020, at 4:42 p.m. included, "After resident sent to ED [emergency department], this nurse tried calling family, did not leave a message due to phone number a business. [medical doctor MD-A] is going to try calling family change of condition. Ambulance took resident to ED [emergency department]." R136's medical record lacked evidence that staff provided written bed hold notice to the resident or resident representative at the time of transfer to the hospital, or within 24 hours of emergent transfer. Further review of R136's paper chart, and documents scanned into the electronic medical record failed to provide evidence that a written bed hold notice was provided. A copy of a bed hold notice for the hospitalization was requested, but not provided. During an interview on 2/24/21, at 8:10 a.m. the director of nursing (DON) she did not see documentation of a bed hold in R136's medical record. At, 8:31 a.m. the DON stated registered nurse (RN)-A informed her the facility had never	F 625	Licensed nursing staff will be in-serviced on the Baseline care plan process and requirements by April 14, 2021.Licensed nurses starting after April 14, 2021 will be in serviced during orientation on this process. DON/designee will validate in first 24 hours, baseline care plan meeting scheduled. DON/designee will validate 48 hour baseline care plan complete with diagnosis related interventions. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON or designee will audit care plans 2x/week for one month then 1 x wk for two months. Results of finding will be reviewed in QAPI monthly to validate compliance after 3 months.	

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F 625	Continued From page 41 done a bed hold in all the years RN-A had worked there and stated RN-A had told her they would only do a bed hold if the facility was full. The DON stated her expectation was when a resident goes to hospital, staff inform family, talk to the resident before they leave and have the resident sign the bed hold form in possible. The DON stated the staff should inform the family they had a packet to sign for the bed hold. The DON stated a copy of the bed hold would be given to the resident or representative and a copy would be kept for the facility. During an interview on 2/26/21, at 9:26 a.m. registered nurse (RN)-A stated when the census was above a certain percentage a bed hold was needed, but if census was below that percentage do not require a bed hold. RN-A stated she was unaware of the percentage requirement. RN-A stated she has never issued a bed hold. During an interview on 2/26/21, at 10:07 a.m. family member (FM)-A stated when R136 was hospitalized the facility did not offer a bed, they would always would just take her back. Resident #2 R2's progress notes dated 11/5/2020, at 5:00 p.m. included "Resident is currently admitted to [name of hospital] for surgery revisitation [sic]. He is currently on a bed hold status. " R2's progress note dated 12/21/2020, at 4:34 p.m. included, "received call from wife stating resident is to be sent to [name of hospital] ED [emergency department]. Resident in agreeance. NP [nurse practitioner] updated."	F 625		

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F 625	Continued From page 42 R2's progress note dated 1/25/2021, at 10:20 a.m. included, "Resident request to be sent to ED. c/o [complained of shortness of breath." The note indicated the physician was updated. R2's medical record lacked evidence that staff provided written bed hold notice to the resident or resident representative at the time of transfer to the hospital, or within 24 hours of emergent transfer. Further review of R2's paper chart, and documents scanned into the electronic medical record failed to provide evidence that a written bed hold notice was provided. A copy of a bed hold notice for the hospitalization was requested, but not provided. During an interview on 2/26/2021 at 2:00 p.m. director of nursing (DON) indicated she did not see documentation of a bed hold in 136's medical record for the 3 hospitalizations. The Transfer and Discharge (including AMA [against medical advice]) policy dated 2020 included, "Provide notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer." The Social Services Bed-Hold Policy dated 9/2011 included, "2. At the time of transfer or therapeutic leave, the charge nurse or social worker will provide the resident and/or responsible party a written copy of the policy. 3. In case of emergency transfer, the charge nurse or social worker will contact the responsible party within twenty-four (24) hours to provide information regarding the policy. 4. When the	F 625		

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F 625	Continued From page 43 facility is at ninety-six (96) percent occupancy or greater for that month, any private pay or Medicare person who requests a bed-hold will pay thirty (30%) of the per diem case mix rate assigned at the time of transfer or leave, foe each day of bed-hold that is requested. 5. When the is at ninety-six (96) percent occupancy or greater for that month, any Medical Assistant recipient will be offered a bed-hold covered by Medical Assistance for eighteen (18) days per hospitalization, and thirty-six (36) days per year for therapeutic leaves. 6. If the occupancy rate is below ninety-six (96) percent for that month the facility will offer the resident or responsible party a bed-hold, but will not require payment for the eighteen (18 days per hospitalization or thirty-six (36) days per year for therapeutic leaves.	F 625		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of	F 640		4/14/21

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F 640	Continued From page 44 transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure timely submission of a quarterly Minimum Data Set assessment (MDS) for 1 of 3 (R10) records reviewed for resident assessments. R10's medical record identified last scheduled	F 640	1. Immediate action(s) taken for the resident(s) found to have been affected include: R10 MDS was completed and accepted on 3/1/21. 2. Identification of other residents having the potential to be affected was	

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F 640	Continued From page 45 Minimum Data Set (MDS) assessment was completed and submitted was on 7/2/2020. R10's medical record identified a quarterly MDS assessment was signed by responsible parties on 1/20 and 1/22/21, however had not been successfully submitted and/or transmitted; R10's electronic health record had an error message for the MDS indicating that the assessment had not been submitted. During an interview on 2/26/2021, registered nurse (RN)-A reviewed the R10's MDS records and confirmed that the assessment had been completed and confirmed there was an error message that indicated the assessment was not successfully submitted. RN-A stated that the MDS nurse was responsible for ensuring the assessments were successfully submitted and should have checked the confirmation reports. RN-A stated she would re-submit the MDS now. During an interview on 2/26/2021, at 2:00 p.m. director of nursing stated an expectation MDS assessments were submitted on time. A facility policy was not provided.	F 640	accomplished by: Residents MDS records audited for the past 30 days. Two residents with open MDS have potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The MDS nurse was re-educated on 3/25/21 by the DON and Clinical Operation Specialist on assessments for RAI process/MDS review. Facility has hired a new MDS nurses starting after April 14, 2021. MDS Nurse will be in serviced on plan of correction during orientation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON or designee will audit for MDS compliance 2x/week for one month then 1 x wk for two months. Results of finding will be reviewed in QAPI monthly to validate compliance after 3 months.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		4/14/21

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F 655	Continued From page 46 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a base line care plan for an anticoagulant medication for 1 of	F 655	1. Immediate action(s) taken for the resident(s) found to have been affected include:	

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F 655	Continued From page 47 5 residents (R139) who had a history of side effects of anticoagulant. In addition, the facility failed to develop a baseline care plan for a pressure ulcer that had been identified upon admission for 1 of 3 residents (R138) reviewed for pressure ulcers. Findings include R139 During an interview on 2/22/2021, at 3:30 p.m. R139 sat in his bed, R139 was observed to have a tennis ball size purple/blueish/yellowish bruise on his right upper arm. R139 stated he was just admitted to the facility a couple of days ago, thought the bruise had been there since admission to the facility, did not know how he got the bruise on his arm, but had just starting taking his anticoagulant during hospitalization because his doctor told him to. R139 stated he was taking anticoagulant because he had atrial fibrillation. R139 stated he had quit taking it a couple of months ago when he developed a blister on his foot and it wouldn't stop bleeding, and every time he blew his nose blood was present. R139 stated that since admission to the facility every time he blows his nose there is a little blood again just like there was the last time. R139 stated an unawareness if staff were aware of his bleeding symptoms and was not asked by the staff if he had a history of bleeding while on anticoagulants. R139's Admission Record, indicated R139 had been admitted to the facility on 2/20/2021, with diagnoses that included atrial flutter. R139's list of diagnoses did not identify that R139 had a diagnoses of atrial fibrillation	F 655	R139 care plan was updated 2/26/21 for at risk for abnormal bleeding, spontaneous bleeding, potential hemorrhage and/or increased/easy bruising r/t taking anticoagulant. 2. Identification of other residents having the potential to be affected was accomplished by: Current resident records audit for the past 30 days to ensure that a comprehensive care plan was implemented with all required elements of the individual resident needs. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed nursing staff will be in-serviced on the Baseline care plan process and requirements by April 14, 2021.Licensed nurses starting after April 14, 2021 will be in serviced during orientation on this process. DON/designee will validate in first 24 hours, baseline care plan meeting scheduled. DON/designee will validate 48 hour baseline care plan complete with diagnosis related interventions. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON or designee will audit care plans 2x/week for one month then 1 x wk for two months. Results of finding will be reviewed in QAPI monthly to validate compliance after 3 months.	

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F 655	Continued From page 48 R139's physician orders included Xarelto (reduce the risk of stroke and blood clots) 20 milligrams (mg) by mouth in the morning for atrial fibrillation (order start date 2/20/21). R139's care plan and/or base line care plan did not identify R139 was on an anticoagulant medication and/or was at risk for bleeding and had a history of bleeding during anticoagulant therapy. R139's record lacked evidence R139 was monitored for bleeding, and lacked evidence the bruise on his right upper arm was identified by facility staff. During an interview on 2/23/2021, licensed practical nurse (LPN)-B stated an unawareness of R139's bleeding history, and indicated if a resident was on an anticoagulant, staff should be monitoring for bruising and signs of bleeding. LPN-B indicated an awareness that when R139 blew his nose blood was present. During an interview on 2/23/21, at 5:06 p.m. director of nursing (DON) reviewed R139's care plan and confirmed the lack of a plan of care for the anticoagulant. DON indicated an unawareness of R139's symptoms of bleeding. DON indicated upon admission, R139 should have been asked about his history with the medication in order for staff to appropriately monitor and treat. DON stated the care plan should have identified that R139 was at risk for bleeding and include associated interventions. R138 During an observation on 2/24/2021, at 1:36 p.m.	F 655		

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F 655	Continued From page 49	F 655		

R138 laid on his back in bed. Nursing assistant (NA)-F and NA-G assisted the R138 in changing incontinent brief. Both NA's indicated they were not aware of any wounds present on R138's bottom. When NA's cleaned both stated there were no wounds present, however was observed to have a coccyx wound and a inner left gluteal fold open wound that was approximately the size of a nickel. Director of nursing (DON) entered the room, confirmed the presences of both wounds and obtained measurements; coccyx wound was a stage 2=0.5 cm x 1.0 cm x 0.2 cm in depth, and the left buttock wound was a superficial stage 2 that measured 2.5 cm in circumference with a depth <0.1 mm.

R138's Admission Record, indicated R138 was admitted to the facility on 2/12/2021, with diagnoses that included obesity, diabetes type 2, and schizophrenia.

R138's Admit/Readmit Assessment dated 2/12/2021, section C. Skin Integrity, identified R138 had a pressure ulcer to his sacrum. The assessment did not include any further description of the ulcer.

R138's Weekly Wound Assessment dated 2/18/2021, identified that R138 had a sacrum ulcer however, did not identify the stage of ulcer. The assessment included ulcer measures of 0.2 centimeters (cm) x 0.5 cm, no depth was documented. The assessment did not identify nor include treatment plan or interventions to treat the ulcer.

Although R138's baseline care plan and/or care plan dated 2/12/2021 identified that R138 had

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F 655	Continued From page 50 impaired skin integrity related to a surgical wound it did not address the sacral pressure area. During an interview on 2/25/2021, at 11:41 a.m. director of nursing (DON) confirmed there was not a base line care plan or a care plan that identified the presence of the pressure ulcer identified upon admission. DON stated the ulcer should have been included on the care plan. An undated Facility policy Baseline Care Plan included, It is the policy of the facility to develop a baseline care plan within 48 hours of admission. Along with the baseline care plan is a summary of care that is provided to the resident and representative in a language they can be understood.	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to perform the 3 safety checks per standard of practice prior to administering medication for 3 of 7 residents (R18, R21, R33) observed during medication administration. Finding include: R18's current physician orders included: Humalog Mix (insulin) 75/25 suspension 100	F 658	1. Immediate action(s) taken for the resident(s) found to have been affected include: R18, medication dose was correct. R33, medication dose was correct. R21, medication dose was correct. LPN-A was immediately educated on performing 3 safety checks for each medication administered and educated on laptop provided for medication administration. In service on correct	4/14/21

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F 658	Continued From page 51 unit/ml (units per milliliter). Inject 45 units subcutaneously in in the morning for diabetes, give before breakfast. On 2/24/21, at 7:45 a.m. licensed practical nurse (LPN)-A was observed preparing R18's insulin for administration. LPN-A had a sheet of paper with resident names on it and insulin dosages for each resident. LPN-A removed R18's Humalog kwik-pen insulin from the medication cart and after applying the needle and priming the pen, dialed up 45 units. LPN-A did not have a computer on the medication cart to check the resident order against the label on the pen. LPN-A stated the facility didn't have enough computers for every medication cart so she had to check the orders ahead of time in the computer prior to administering the insulin. LPN-A administered the insulin to R18, then moved on to the next resident to administer medication. R33's current physician orders, included: Novolog 100 unit/ml. Inject 5 units subcutaneously with meals for hyperglycemia hold if BS<80 (blood sugar less than 80). Give in addition to sliding scale insulin. Novolog solution 100 unit/ml. Inject as per sliding scale: if 151-200=3, 201-250=7, 251-300=10, 301-400=10. Notify provider of BS greater than 400, subcutaneously with meals. On 2/24/21, at 7:52 a.m. LPN-A asked a nursing assistant (NA) what R33's blood sugar reading was that morning; NA responded 167. LPN-A removed R33's Novolog Flexpen from the medication cart and after applying the needle and priming the pen, dialed up 8 units. LPN-A	F 658	process completed on 3/26/21. 2. Identification of other residents having the potential to be affected was accomplished by: Residents receiving a medication pass by the LPN have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed nursing staff will be in serviced on facilities policy related medication administration by April 14, 2021.Licensed Nurses hired after April 14-2021 will be in serviced during orientation on this process. Licensed Nurse will have a medication pass observation completed by April 14,2021. Licensed Nurses hired after April 14-2021 will be in serviced during orientation on this process. Licensed Nurse will have a medication pass observation completed biannually. Facility purchased new laptop for nurse only medication cart. Nurses will be trained on that by April 14, 2021. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON or designee will randomly audit LPN medication administration 2x/week for one month then 1 x wk for two months. Results of finding will be reviewed in QAPI monthly to validate compliance after 3 months.	

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F 658	Continued From page 52	F 658		

confirmed R33's order was for 5 units including sliding scale, which at a value of 167 would be 3 additional units. LPN-A did not review R33's physician order prior to preparing the insulin though did refer to her sheet of paper.

R21's current physician orders, included: acidophilus (a probiotic), give one tablet via G-tube in the morning for supplement, ascorbic acid (vitamin C) give one tablet via G-tube two times a day for supplement, hydrochlorothiazide 25 mg, give one tablet in the morning for pulmonary congestion, Nystatin suspension 1,000,000 unit/ml, give 5 ml by mouth four times a day for thrush pain white area on tongue with tongue compressor, Keppra solution 100 mg/ml, give 500 mg via G-tube two times a day related to convulsions, Miralax powder, give 17 grams via G-tube in the morning for constipation.

On 2/25/21, at 8:02 a.m. LPN-A was observed setting up the above medications for R21. LPN-A stated R21's medications were kept in the medication room, and further stated she had checked R21's medication orders in the computer prior to going into the med room. LPN-A set up the medications without comparing the medication labels to the orders in the computer.

When interviewed on 2/25/21, at 8:55 a.m. (following administration of R21's medications), LPN-A confirmed there was a need for a computer on the med cart utilized by the licensed nurses. LPN-A further confirmed the facility did not have a computer available to utilize for that cart when setting up medication. LPN-A agreed having a computer available to see the order

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F 658	Continued From page 53 during set up and to triple check, would be a more appropriate procedure and confirmed she was performing the medication administration could set the nurse up for errors. When interviewed on 2/24/21, at 1:20 p.m. the director of nursing (DON) stated when she had started at the facility 2 weeks prior had identified the need for a computer on the med cart utilized by the licensed nurse, and supplied nursing with a 3rd computer for that cart. DON confirmed she expected nursing staff to utilize that computer when administering medication. The policy titled, Administering Medications, dated 2018, indicated: Perform the 3 safety checks for each medication administer: Read the label and compare to the MAR when you pick up the medication. Read the label and compare to the MAR when preparing the medication for administration. Read the label and compare to the MAR just prior to administration.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's	F 661		4/14/21

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F 661	Continued From page 54 representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a comprehensive discharge summary for 1 of 1 resident (R36) reviewed for discharge. Findings include: R36's face sheet, identified an admission date to facility of 11/30/20 with diagnoses including hypertension (high blood pressure), personal history of diabetic foot ulcer and diabetes. Review of R36's discharge instructions dated 12/16/20, indicated R36 discharged to the [name of Hotel], would have Home Services and listed the company that would provide services. The discharge instructions further indicated written, and verbal education was completed by reviewing the medication administration record (MAR) and treatment administration record (TAR) with R36. The discharge instructions provided	F 661	1. Immediate action(s) taken for the resident(s) found to have been affected include: R36 discharged from facility 12/16/20. 2. Identification of other residents having the potential to be affected was accomplished by: Audit completed of current residents for past 30 days for discharge. No other residents found to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed nursing staff will be in serviced on facility policy r/t discharge/transfer comprehensive summary by April 14, 2021. Licensed Nurses hired after April 14-2021 will be in serviced during orientation on this process. DON/Designee will review residents with a planned discharge their comprehensive	

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F 661	Continued From page 55 were not signed by the resident or family and did not include copies of medications, MAR, or TAR. R36's discharge instructions did not include cognitive patterns, communication, vision, mood behavior patterns, psychosocial well-being, continence, diagnosis and health conditions, skin condition, and activity pursuit. During an interview on 2/25/21, at 8:43 a.m. the receptionist stated was unable to find a copy of R36's signed discharge instructions and information provided to R36 upon discharge from the facility. During an interview on 02/25/21, at 8:45 a.m. the director of nursing (DON) verified R36's discharge instructions did not include cognitive patterns, communication, vision, mood behavior patterns, psychosocial well-being, continence, diagnosis and health conditions, skin condition, and activity pursuit. The DON stated the management company was in the process of building a discharge summary for the facility to complete. The DON verified R36's discharge instructions did not meet the requirements of the regulation. The Transfer and Discharge (including AMA[against medical advice]) policy dated 2020 included, Anticipated Transfers or Discharges-initiated by the resident. Obtain physician's orders for transfer or discharge and instructions or precautions for ongoing care. A member of the interdisciplinary team completes relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the	F 661	post discharge plan in the morning clinical meeting prior to discharge for outstanding care areas. How the corrective action(s) will be monitored to ensure the practice will not recur: DON/Designee will audit resident residents record 2x/week for one month then 1 x wk for two months for completed comprehensive post discharge planning (Recapitulation of stay). Results of finding will be reviewed in QAPI monthly and compliance validated after 3 months.	

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F 661	Continued From page 56 Discharge Summary is complete and includes, but not limited to the following: A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy. And pertinent lab radiology and consultation results. A final summary of the resident's status. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter.) A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment. Orientation for transfer or Discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team. Assist with transportation arrangements to the new facility and any other arrangements as needed. The comprehensive, person-centered care plan shall contain the resident's goal for admission and desired outcomes and shall be in alignment with the discharge. Supporting documentation shall include evidence of the resident's or resident's representative's verbal or written notice of the intent to leave the facility, a discharge plan, and documented discussions with the resident and/or resident representative.	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		4/14/21

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F 684	Continued From page 57 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify, complete a comprehensive skin assessment of impaired skin integrity of a foot ulcers upon admission for 1 of 2 residents (R139) reviewed for impaired skin integrity. In addition, the facility failed to monitor and evaluate fluid intake for a physician prescribed fluid restriction and failed to consistently monitor and evaluate edema for 1 of 1 residents reviewed (R2) who had a diagnosis of congestive heart failure and had a history of hospitalization related to fluid overload. Finding include: During an observation and interview on 2/22/2021, at 3:30 p.m. R139 sat on his bed. R139 stated he was admitted to the facility a few days ago because of a gangrene infection in his groin that needed dressing changes that he could not see to do himself. When asked if he had any other sores or pressure ulcers, R139 said he had an open sore on the bottom of right foot the size of a dime that used to be a big blister. R139 stated there was a dressing over the wound now that had been on since he had been admitted to the hospital and has not been changed. R139	F 684	1. Immediate action(s) taken for the resident(s) found to have been affected include: R139 skin is being monitored. DON and RN-A did a skin assessment immediately 2/23/21 and documented the PU findings on the lower extremities. MD was notified on 2/23/21 regarding skin assessment findings, physician orders followed as indicated. R2 Fluid intake monitoring medication administration MAR was corrected to include breakdown of resident fluid restriction per 24 hours. R2 Edema assessments completed on 3/26/21. LPN-B was verbally educated on requirements to complete full body skin assessments on admissions on 2/24/21. Formal in service was completed 3/26/21. RN-A was verbally educated on requirements to complete full body skin assessments on admissions on 2/24/21. Formal in service was completed 3/26/21. 2. Identification of other residents having the potential to be affected was accomplished by:	

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F 684	Continued From page 58 added he also had some areas on two of his toes of the left foot that he thought were healing. R139 was asked if staff had seen the wounds to his feet, in response R139 said noone here had looked at the wounds and had not asked about any other skin conditions. R139's Admission Record, indicated R139 had been admitted to the facility on 2/20/2021, with diagnoses of diabetes type 2, Fournier gangrene, chronic obstructive pulmonary disease, and morbid obesity. R139's hospital discharge summary dated 2/19/2021, indicated R139 had been admitted to the hospital on 2/8/2021 and discharged on 2/19/2021. The summary also included diagnoses of diabetic peripheral neuropathy and congestive heart failure that was not included on the facility's list of diagnoses. The discharge summary identified the groin wound and the treatment of, however did not identify that R139 had ulcerations to his feet. R139's Admit/Readmit Assessment dated 2/20/21, in section titled Skin Integrity, did not identify the impaired skin integrity to R139's feet. During an observation and interview on 2/23/2021, at 8:52 a.m. R139 laid in bed, registered nurse (RN)-A and director of nursing (DON) were present in the room to change the dressing to R139's groin. At the completion of the dressing change both RN-A and DON were going to leave the room, surveyor requested RN-A to look at R139's feet. RN-A took off R139's right sock exposing a gauze bandage wrapped around the top of his foot. RN-A donned gloves, removed	F 684	Facility has had 3 admissions in past 30 days. Skin assessments completed upon time of admission. Five other current residents on fluid restrictions. Current fluid restriction orders include 24-hour breakdown of fluid intake. Current residents with MD orders for edema monitoring were reviewed. No other failures to monitor edema noted. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed nursing staff will be in serviced on skin assessments and PU findings and documentation upon admission by April 14, 2021. Licensed Nurses hired after April 14-2021 will be in serviced during orientation on this process. Licensed Nurses and TMA's will be in serviced on fluid restriction resident process. This is including Fluid Restriction breakdown on MAR and Care Plan by April 14-2021. Licensed Nurses and TMAs hired after April 14-2021 will be in serviced during orientation on this process. DON/Designee will review new fluid restriction order, new edema monitoring orders during the following mornings clinical meeting. The facility now places significant changes r/t to skin assessment, edema monitoring notifications on the 24-hour report. 4. How the corrective action(s) will be	

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F 684	Continued From page 59 the dressing that exposed the ulceration on the bottom of R139's foot. RN-A measured the wound; stated it was 1.0 centimeters (cm) x 2.0 cm x 0.1 cm in depth. RN-A then removed R139's left sock, there was an area on the big toe with no dressings were present. RN-A measured the wound on the great toe; 2.9 cm x 1 cm with of depth of 0.2 cm. R139's lower extremities were observed to be very dry with thick scaley skin. R139 stated he had been putting vaseline on them at home. R139's corresponding progress note dated 2/23/2021, at 9:35 a.m. included "Contact [name of wound clinic]- updated on dry feet, left great toe, and right plantar foot. Initial wound assessments completed. Orders recieved for hydrofera blue and cover q [every] 3 days to right plantar. Keep left great toe clean and dry. Change dressing q 3 days. Vaseline to feet." During an interview on 2/23/2021, at 3:55 p.m. licensed practical nurse (LPN)-B stated he had worked on 2/20/2021, had changed the dressing to R139's groin however did not know anything about the impaired skin integrity to R139's feet. During an interview on 2/23/2021, at 3:59 p.m. nursing assistant (NA)-E stated she had provided cares to R139 the last couple of days and had worked on 2/20/21 when R139 was admitted. NA-E stated she was only aware that R139 had a wound in his groin and nowhere else. NA-E stated on 2/20/21, she had asked what R139 needed help with and he wanted his socks left on so she had not seen his feet. NA-E stated she did not ask R139 if she could inspect his feet for impaired skin integrity and did not ask if he had	F 684	monitored to ensure the practice will not recur: DON or designee will audit for MDS compliance 2x/week for one month then 1 x wk for two months. Results of finding will be reviewed in QAPI monthly to validate compliance after 3 months.	

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F 684	Continued From page 60 any sores. During an interview on 2/23/2021, at 4:47 p.m. RN-A stated she had not previously been aware of the wounds on R139's feet before today. During an interview on 2/23/2021, at 5:06 p.m. DON stated she had completed R139's admission, however reported to the evening shift nurse she had not completed the entire body audit and asked that the nurse complete it. DON stated she did not follow-up with the nurse and had assumed that it had been completed. DON stated she had not been previously aware of the wounds to R139's feet. DON stated it was expected that a full body audit be completed upon admission, and indicated staff should be looking at or asking independent residents to complete body audits. R2 During an observation on 2/26/21, at 8:42 a.m. R2 sat in his wheelchair in his room with his legs down in the dependent position. R2 had tubi grips on to both legs, both legs observed to be edematous with the right worse than the left. R2 stated he was on a 1.5 liter fluid restriction, and thought he had been following. R2 stated that the facility passed water and their was water in the sink. R2 stated he elevated his legs at night to help with the swelling, and were up in the air from 7:00 p.m. to 6:00 a.m. R2 stated staff weighed him before breakfast and staff checked for edema but not daily. R2's Admission Record, included diagnoses of	F 684		

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F 684	Continued From page 61 hypertensive heart and chronic kidney disease with heart failure, and shortness of breath. R2's scheduled (PPS) Minimum Data Set assessment dated 1/13/2021, identified R2 did not have cognitve impairment and indicated R2 was not administered diuretic medications. R2's physician orders included: -Daily weight for edema (Start date 12/5/2020) -Fluid restriction 2000 milliliters (ml) per day (start date 1/28/2021) - Tubi grips- on in the morning off at bedtime for edema (start date 12/17/2020) -Metolazone (diuretic) 2.5 milligrams (mg) every Monday, Wednesday, Friday for fluid restriction (start date 2/15/2021) -Tousemide (diuretic) 40 mg twice per day for congestive heart failure (start date 1/28/2021) R2's nutritional care plan, included: follow fluid restriction 2 liters per day, record and monitor intake daily, weigh resident per facility protocol. R2's care plan identified R2 had diagnoses of hypertension and congestive heart failure; associated interventions included monitor for and document any edema notify physician, weight weekly, monitor/document/report as needed any signs/symptoms of congestive heart failure. EDEMA R2's record was reviewed from 2/10/21 to 2/22/21, R2's record did not include consistent edema monitoring and evaluation according to the care plan and physician orders. R2's progress note dated 2/11/2021, at 2:20 p.m. indicated R2 had a hard cast removed and cam	F 684		

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F 684	Continued From page 62 boot applied to his right foot, and weight variance may be related to the new device. Breath sounds even and unlabored lung sounds clear. Bilateral lower edema 1+. Tubigrips on both lower extremities and left arm. A subsequent note at 9:17 p.m. indicated at 6:00 p.m. R2 had showed nurse several fluid filled blister and open wounds on the right leg were the cast was. R2's progress note dated 2/20/21, included "... +3 pitting edema to lower legs and feet bilaterally. Left arm edema present from elbow to fingers. R2's progress note dated 2/21/21, at 2:01 a.m. included "resident coughing 0100 [sic] blood. Listening to lungs wheezing could be heard in his right upper lungs." A subsequent note at 5:50 a.m. included, "Resident die [sic] not cough out anymore bloody phlegm, vitals stable will continue to monitor resident for change of condition and update primary provider. R2's weight change note dated 2/21/21, indicated R2 triggered for weight gains... R2's progress note dated 2/21/21, at 8:00 p.m. included "lungs has a bit of wheezing in the left upper side." Daily weights identified fluctuations in R2's weights and indicated R2 was not weighed at the same time every day. 2/11/21, at 11:32 a.m. - 262 pounds lbs. 2/12/21, at 10:21 a.m. - 265.2 2/13/21, at 1:42 a.m. -264.4 2/14/21, at 9:54 a.m.-265.2 2/15/21, at 2:02 p.m. -264.2 2/16/21, at 12:52 p.m. -265.4	F 684		

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F 684	Continued From page 63 2/17/21, at 11:14 a.m.-261.8 2/18/21, at 10:55 a.m.-266.0 2/19/21, at 12:49 p.m.-269.2 2/20/21, at 12:49 p.m.-266.4 2/21/21, at 1:07 p.m. -266.8 2/22/21, at 9:55 a.m. -265.4 FLUID INTAKE R2's record lacked evidence of monitoring and evaluation of fluid intake according to physician orders and the care plan. R2's Fluid Intake record was reviewed from 2/10 to 2/22/21, the record lacked consistent recording of fluid intake, and the record lacked evidence of evaluation of 24 hour fluid intake in order to identify fluid volume deficits and/or overages. Based on the documentation it cannot be determined if R2's 2 Liter fluid restriction was followed according to physician orders. On 2/10/21, breakfast intake documented as "not applicable", for lunch and dinner intake was 240 ml. On 2/11/21, breakfast intake documented as "0", lunch 200 ml, and dinner 200 ml, dinner documented as "not applicable" On 2/12/21, breakfast was 225 ml, lunch 200 ml, dinner- was left blank On 2/13/21, breakfast was documented as "not applicable" lunch 240 ml, dinner 240 ml On 2/14/21, breakfast was 240 ml, lunch 240 ml, dinner documented as "not applicable" On 2/15/21, breakfast was 120 ml, lunch 120 ml, dinner was left blank. On 2/16/21, no fluid intake was recorded for the day On 2/17/21, breakfast 240 ml, lunch 240 ml,	F 684		

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F 684	Continued From page 64 dinner was left blank. On 2/18/21, 240 ml was recorded for each meal. On 2/19/21, breakfast was left blank, lunch 240 ml, dinner was left blank On 2/20/21, breakfast was left blank, both lunch and dinner intake was 240 ml On 2/21/21, breakfast was left blank, lunch 120 ml, dinner 180 ml. During an interview on 2/24/2021, at 2:31 p.m. registered nurse (RN)-B stated nurses are documenting fluid intake on the TAR's [treatment administration record]. RN-B reviewed the areas in R2's record where fluid intake was documented and stated it could not be determined how much fluid intake R2 consumed on a daily basis. RN-B stated the dietician would be a good person to evaluate daily fluid totals. During an interview on 2/24/2021, at 2:38 p.m. NA-D stated dietary staff recorded fluid intake in the computer after they picked up meal trays. During an interview on 2/24/2021, at 2:39 p.m. NA-J stated she used to work in dietary. NA-J stated dietary staff would record the amount of intake in the computer for each meal, if dietary staff did not have time on their shift, the next shift would record it for them. NA-J stated they did not record any other intake besides what the resident was provided with meals. NA-J indicated an unawareness of who was documenting the amount of fluid intake outside of meals. During an interview on 2/25/2021, at 8:15 a.m. nursing assistant (NA)-I stated she was not sure if R2 was on a fluid restriction or not. NA-I stated NA's did not record fluid intake and that kitchen	F 684		

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F 684	Continued From page 65 people tracked that. During an interview on 2/26/2021, at 8:51 a.m. trained medication assistant (TMA)-A stated when she passed medications she did not record the amount of fluid intake and dietary staff tracked fluid intake. During an interview on 2/26/2021, 9:18 a.m. RN-A stated if a resident was on a fluid restriction, the dietician determined how much fluid was divided over each meal, how much the resident could have in his room, and the amount allowed for medication passes. RN-A stated NA's were supposed to communicate to the nurse if the resident was requesting additional fluids outside of what they were provided. RN-A stated "I don't believe that there is someone evaluating the 24 hour totals, our dietician may go in but I can't confirm that." During an interview on 2/25/2021, at 11:22 a.m. director of nursing (DON) reviewed R2's fluid intakes and stated the facility did not have a solid way fluid intakes were being documented and evaluation of the intakes was not being completed. During an interview on 2/26/2021, at 9:39 a.m. certified dietary manager (CDM) stated dietary and housekeeping staff pass water twice per day, if a resident is on fluid restriction it is identified on a sheet of paper. CDM stated dietary staff are supposed to record fluid intake after each meal in the computer. CDM stated an unawareness of who was evaluating 24-hour daily fluid intakes. CDM stated an unawareness who was documenting fluid intake provided outside of	F 684		

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F 684	Continued From page 66 meals such as fluids given during activities, during medication passes, or extra amounts the resident requests. Facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocal dated 2/2014 included 2. The nurse shall descrbe and docuemtn reprot the following: Full assessment of pressure sore including location, size, stage, length, width, and depth, presence of exudates or necrotic tissue. Current treatments, including support surfaces. 3. The staff will examine the skin of a new admission for ulcerations or alterations in skin. Facility policies for management of congestive heart failure/fluid intake monitoring/edema managemet were requested and were not provided.	F 684		
F 686 SS=D	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:	F 686		4/14/21

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F 686	Continued From page 67 Based on observation, interview, and document review the facility failed to comprehensively assess, monitor, and treat a worsening pressure ulcer for 1 of 3 residents (R138) reviewed for pressure ulcers. Findings include During an observation on 2/24/2021, at 1:36 p.m. R138 laid on his back in bed. Nursing assistant (NA)-F and NA-G assisted R138 with changing incontinent brief. Both NA's indicated they were not aware of any wounds present on R138's bottom. When NA's cleaned R138 and said there were no wounds present, however when R138's buttocks were observed, R138 was observed to have a coccyx wound and a inner left gluteal fold open wound that was approximately the size of a nickel. R138 denied having discomfort or pain related to the impaired skin integrity. Director of nursing (DON) entered the room, confirmed the presences of both wounds and obtained measurements; DON stated coccyx wound was a stage 2- 0.5 cm x 1.0 cm x 0.2 cm in depth, and the left buttock wound was a superficial stage 2 that measured 2.5 cm in circumference with a depth <0.1 mm. R138's Admission Record, indicated R138 was admitted to the facility on 2/12/2021, with diagnoses that included obesity, diabetes type 2, and schizophrenia. R138's Admit/Readmit Assessment dated 2/12/2021, section labeled Skin Integrity, identified R138 had a pressure ulcer to his sacrum with no further information.	F 686	1. Immediate action(s) taken for the resident(s) found to have been affected include: R 138 was discharged on 3/16/2021. (NA)-F was in serviced on residents Kardex and the repositioning needs of a resident. (NA)-G was in serviced on residents Kardex and the repositioning needs of a resident. (LPN)-A was in serviced on how to locate in the electronic health record a resident's skin status. 2. Identification of other residents having the potential to be affected was accomplished by: Current resident with pressure ulcers reviewed for appropriate measurements and care planning. No others at risk identified. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing staff will be in serviced on how to read a resident Kardex for loss of skin integrity and re position requirements by April 14-2021 Facility nursing staff hired after April 14-2021will be in serviced during orientation on this process. Licensed Nurses will be in serviced by April 14-2021on how to locate and update a resident's skin status in the electronic health record. Facility Licensed Nurses hired after April 14-2021 will be in serviced during orientation on this process. DON/Designee will validate new / re admissions with pressure ulcers have	

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F 686	Continued From page 68 Although R138's baseline care plan and/or care plan dated 2/12/2021 identified that R138 had impaired skin integrity related to a surgical wound it did not address the sacral pressure area. R138's activities of daily living care plan dated 2/15/2021, indicated R138 required one staff assist for toileting and transfers, and bed mobility, R138 could reposition himself. R138's bowel and bladder incontinence care plan dated 2/15/2021, included "check resident every two hours and assist with toileting as needed. Provide pericare after each incontinent episode." R138's diabetic care plan directed staff to "Check all of body for breaks in skin and treat promptly as ordered by doctor" and "Monitor/document/report to MD PRN [as needed] for s/sx [sign/symptoms] of infection to any open areas." R138's Weekly Wound Assessment dated 2/18/2021, identified that R138 had a sacrum ulcer however, did not identify the stage of ulcer. The assessment included ulcer measures of 0.2 centimeters (cm) x 0.5 cm, no depth was documented. The assessment did not identify nor include a specific treatment plan or interventions to treat. R138's progress note dated 2/24/2021, at 2:35 p.m. included, "a special visit with [name of person]. Butt assessment completed. Orders received to clean cleanse with NS [normal saline]. Pat dry. Apply skin prep to periwound. Cover with 2 x 2 [gauze]- cover with tape. Twice per day. Notify provider if drainage present." R138's skin wound note dated 2/24/2021, at 2:46 p.m. included, "Type of Wound: unknown" and	F 686	complete measurements, Baseline care plan that includes location and individualized reposition needs during the next morning clinical meeting. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON/Designee will audit new admissions 2x/week for one month then 1 x wk for two months for appropriate documentation of loss of skin integrity, Baseline care plans and repositioning schedule. Results of finding will be reviewed in QAPI monthly and compliance validated after 3 months.	

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F 686	Continued From page 69 "sacral midline- 0.1 x 0.1 x 0.2 cm- unable to visualize the base of wound. No drainage observed from wound. Special visit for NP [nurse practitioner]. Resident denies pain." The note was not authored by the DON who physically measured the wound; the measurements were not consistent with measurements stated by the DON at the time the wound was assessed. Weekly Wound Assessment dated 2/24/2021, at 4:16 p.m. did not include the sacral ulcer assessment and only identified "left buttock pressure 0.2 x 0.5 [cm]." Stage of the left buttock pressure area was not identified on the assessment. During an observation on 2/24/2021, at 6:58 a.m. R138 laid on his back with the head of the bed elevated. During an interview and observation on 2/24/2021, at 8:00 a.m. R138 continued to lay in the same position. Licensed practical nurse (LPN)-A said R138 did not have any pressure ulcers on his bottom. During an observation on 2/24/2021, at 8:30 a.m. R138 continued to lay in the same position, an unidentified nursing assistant (NA) entered the room and assisted R138 with eating his breakfast. During a subsequent observation at 9:00 a.m. the NA had left the room, and R138 continued to be in the same position. During an interview and observation on 2/24/2021, at 11:55 a.m. R138 laid in bed on his back with the head of the bed elevated. NA-F stated she had just finished feeding him lunch	F 686		

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F 686	Continued From page 70	F 686		

and had not repositioned R138 before or after. NA-F stated R138 wasn't feeling well today, had not done anything with him prior to or after assisting him with lunch, and stated he let us know when he needed something, however oddly today had not put on his light at all so far.

During an interview on 2/24/2021, at 1:40 p.m. NA-F stated her and NA-G changed R138 between 6:00 a.m. and 7:00 a.m., he had been wet and had not put on his call light. NA-F stated we (NA-F and NA-G) didn't get him dressed until 11:15-11:30 a.m., because he hadn't been feeling well that morning; NA's stated R138 was wet. NA's both confirmed between the times of 6-7:00 and 11:15-11:30, R138 had not been repositioned and/or offered repositioning because he had not put on his call light. NA-A stated, "I know that's a really long time apart but we try our best." When asked how often R138 was supposed to be repositioned, neither aide could articulate how often R138 should be re-positioned.

During an interview on 2/25/2021, at 11:41 a.m. director of nursing (DON) reviewed R138's record, confirmed the admission assessment was not complete, the ulcer had worsened since measured on 2/18/2021, and lacked a treatment plan. DON confirmed the facility did not have a system in place to determine and individualized turning and repositioning schedule in order to prevent pressure ulcers and/or prevent deterioration of existing ulcers. DON stated the nursing assistance should have repositioned R138 according to the care plan or at least every two hours; If residents refused positioning the expectation was to document the refusal and re-approach.

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F 686	Continued From page 71 Facility policy Pressure Ulcer Risk Assessment dated 2/2014 included, the purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers. -Assessment: 2. Skin Assessment. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. 3. Monitoring: staff will perform routine skin inspections (with daily care), b) nurses are to be notified to inspect skin if skin changes are identified. 4) because a resident at risk can develop a pressure ulcer within 2-6 hours of onset of pressure, the at risk resident needs to be identified an have interventions implemented promptly to attempt to prevent pressure ulcers. The admission evaluation helps define those initial care plan approaches and interventions. Facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 2/2014 included: The nurse shall describe and document report the following: Full assessment of pressure sore including location, size, stage, length, width, and depth, presence of exudates or necrotic tissue. Current treatments, including support surfaces. The staff will examine the skin of a new admission for ulcerations or alterations in skin.	F 686		
F 689 SS=D	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	F 689		4/14/21

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F 689	Continued From page 72 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess each fall, identify causative factors to determine the reason for falls and identify potential effective interventions to decrease the risk for future falls for 2 of 2 residents (R137, R24) reviewed for accidents. Findings include: R137 was observed on 02/23/21, at 3:32 p.m. sitting on the side of her bed, gripper socks, tray table in front of her. R137's face sheet, identified an admission date to facility of 2/12/21 with diagnoses including altered mental status, avoidant personality disorder, diabetes and borderline personality disorder. R137's Fall Risk Assessment dated 2/15/21 indicated R137 was at moderate risk for fall with a score of 13. R137's fall care plan included, "I am at risk for falls r/t [related due] deconditioning, unaware of safety needs. Goals include, "The resident will be free of falls through the review date. Interventions included, "Anticipate and meet the resident's need. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs	F 689	1. Immediate action(s) taken for the resident(s) found to have been affected include: R137 Risk assessment completed on 2/24/21, new interventions initiated as appropriate. R24 Risk assessment completed on 2/24/21, new interventions initiated as appropriate. 2. Identification of other residents having the potential to be affected was accomplished by: Audit completed of current residents for past 30 days for falls. Twelve other residents found to be potentially affected, review of record noted. Interventions put in place. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed staff educated on new incident program, process, and expectation including root cause analysis, cause factors, and interventions by April 14, 2021. Nursing staff hired after April 14-2021 will be in serviced during orientation on this process. Facility initiated new process of completing fall investigation form for most effected immediate intervention. Facility Nursing staff will be in serviced on fall	

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F 689	Continued From page 73 prompt response to all requests for assistance. Follow facility fall protocol. Pt [Physical Therapy] evaluate and treat as ordered or PRN [as needed]." R137's progress note dated 2/20/2021, at 12:21 p.m. included, "Resident telling CNA [certified nursing assistant] at 1130 that she fell during the night "when it was dark". When this writer approached her states she got up to the bathroom at 0330-0400. Got dizzy and staggered Left then fell to the right. "I passed out". Got up and back to bed not saying anything to anyone. Now c/o [complaining of] back pain mid right side of back. No redness, bruising. VSS [vital signs stable]. Admits having dizzy spells. Encouraged to call for assist with transfers but said "Then I will pee my pants". Also reinforced the need to call right away for staff if falls." R137's medical record lacked documentation of a fall investigation or an interdisciplinary team meeting review of this fall. During an interview on 2/24/21, at 12:53 p.m. the director of nursing (DON) stated she had not been made aware of R137's fall. The DON verified there was not a fall investigation or an interdisciplinary team review of the fall. The DON stated the fall intervention was to encourage R137 to call for assistance per the progress notes. The DON verified she became aware of R137's fall when a surveyor asked for documentation of the fall. The DON stated the licensed practical nurse (LPN)-A did not document on the fall as the fall was not witnessed and LPN-A was unsure if the resident had fallen.	F 689	investigation form by April 14, 2021. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON or designee will audit for falls and a comprehensive assessment of each fall 2/week for one month then 1 x wk for two months. Results of finding will be reviewed in QAPI monthly to validate compliance after 3 months.	

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F 689	Continued From page 74 During an interview on 02/24/21, at 1:15 p.m. LPN-A stated when there is an unwitnessed fall, the person who finds the resident completes a fall investigation. LPN-A stated we need to try to determine the root cause of the fall. The provider and family member are contacted, and you make a progress note regarding the incident regarding everything you have done. LPN-A stated R137 told the CNA (certified nursing assistant) she fell between 11:30 a.m. and 12:00 p.m. that she fell during the night. The CNA (certified nursing assistant) reported to LPN-A and she went in there and asked her what happened. LPN-A stated R137 told me she had got up to go to the bathroom, that it was dark, she stood up started to lean and then when she tried to stand up, she fell the opposite way. LPN-A stated she instructed R137 to call for assist and if she did have a fall to let staff know right away. LPN-A stated she did not fill out the fall investigation form. LPN-A stated she did not do one because it happened during the night and she was not sure what had happened, and she was not sure what the protocol was for something like that. LPN-A stated she did not notify the provider or the family about the fall. LPN-A stated the DON was here when this was going on and stated she was also not quite sure how to handle it. LPN-A stated she probably should have filled out the form. LPN-A verified did not follow the facility procedure for falls and stated that this has never happened to her before when somebody stated they had fallen hours earlier. R24	F 689		

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F 689	Continued From page 75 During an observation on 2/22/2021, at 3:04 p.m. R24 laid in bed with his eyes closed and snoring. R24's call light was laced around bed grab bar, bed was in low position, and fall mat was next to the bed. R24's wheelchair was close to the edge of the mat furthest from the bed. R24's Admission Record, included diagnoses of unsteadiness on feet, lack of coordination, anxiety disorder, altered mental status, cataract, dementia with behavioral disturbance, and abnormalities of gait and mobility. R24's annual Minimum Data Set (MDS) assessment dated 1/6/2021, indicated R24 had severe cognitive impairment and delusions. The MDS identified R24 required extensive assistance from one staff for bed mobility, transfers, and toileting. R24's medical record identified the last fall risk assessment was completed on 11/20/2020. The assessment identified R24 was at high risk for falls. R24's care plan, identified R24 had limited physical mobility related to weakness, dementia, and musculoskeletal impairments. The care plan also included, "is at risk for falls r/t [related to] dementia, inability to transfer self safely, inability to ambulate. Associated interventions included the following; -Education with wife regarding visits (start date 1/3/2020) -Be sure residents call light is within reach, encourage use, and resident needs prompt response to all requests for assistance (start date 2/20/2019)	F 689		

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F 689	Continued From page 76 -floor mat at bedside (start date 2/12/2020) -needs meaningful activities that minimize the potential for falls while providing diversion and distraction. Offer to lay down after activities (start date 2/30/2019). -non-skid strips in front of resident recliner on the floor start date 10/2/2019) -Offer toileting upon rising, before bed, before and after meals and at 10 p.m. Do not leave resident unattended on the toilet (start date 3/17/2020) -Place resident's wheelchair across the room- not close to him when he isn't in the chair (start date 3/17/2020) -Bed in lowest position when R24 is in bed start date (1/3/2020) Facility incident report dated 11/20/2020, at 12:21 p.m. included R24's description of the fall which was documented as "resident states "I wanted you kids to come here and here you are" referring to staff as he was being assisted. The Immediate Action Taken included, "VS [vital signs] obtained and assisted resident to bed, call light within reach, encouraged to use/request for assistance, supervision measures taken throughout the shift, will continue to assess." The remainder of the form that addresses potential causal factors, root cause, and ongoing interventions was blank. R24's corresponding progress note dated 11/20/2020, at 2:56 p.m. included, "resident noted on floor mat at change of shift, writer assessed resident at time. ROM [range of motion] intact VSS [vital signs] and WNL [within normal limits], alert per his baseline, no injury observed at this time, assessed to bed, call light	F 689		

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F 689	Continued From page 77 placed with easy reach, resident able to use call light, at this time bed lowered to the floor, [name of physician] and family both notified. R24's record did not include documentation of root cause analysis, fall investigation, or interdisciplinary team meeting of this fall. During an interview on 2/24/2021, at 2:37 p.m. nursing assistant (NA)-D stated R24 was at risk for falls. NA-D indicated R24 seemed to cycle between good days and bad days. NA-D indicated R24 had days where he was impulsive and would not use his call light and staff had to anticipate his needs. NA-D indicated when R24 had his sleepy days he would make sure to check on him at least every 2 hours. NA-D stated R24's bed needed to be in the lowest position, the floor mat down, call light in place, and his wheelchair near the bed with the breaks locked in case R24 did get up he wouldn't have so far to walk to his chair. During an interview on 2/25/2021, at 4:59 p.m. director of nursing (DON) reviewed R24's record and incident report and confirmed the incident report lacked an investigation into causal factors, determination of root cause, IDT involvement and review/revision of the care plan; DON stated those tasks should have been completed. DON also stated reminding R24 to remember to use his call light was not an appropriate intervention for him because he did not consistently remember to use the call light. Facility policy Fall Risk Assessment dated 12/2007 included, The nursing staff, in conjunction with the attending physician,	F 689		

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F 689	Continued From page 78 consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls. The staff will look for evidence of possible link between the onset of falling (or increase in falling episodes) and recent change sin the current medication regimen. The assessment data shall be used to identify underlying medical conditions that may increase the risk for injury from falls. The staff with support of the attending physician will evaluate functional and psychological factors that may increase fall risk, The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement adequate systems for monitoring fluid intake for 2 of 2 residents (R13 and R23). In addition, the facility failed to ensure the dialysis access site was monitored and assessed upon return to dialysis	F 698	1. Immediate action(s) taken for the resident(s) found to have been affected include: R 13 MDS was corrected on 3/18/21 to include cognition status. R 13 Medication administration record	4/14/21

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F 698	Continued From page 79 treatment, and failed to notify the dialysis center when the dialysis site was bleeding for 1 of 2 residents (R13) reviewed for dialysis. Findings include: R13's Admission Record, included diagnosis of end stage renal disease, dependence on renal dialysis, and essential hypertension. R13's annual Minimum Data Set (MDS) assessment dated 12/6/2020, did not identify R13's cognition. The MDS indicated R13 required staff assistance for activities of daily living and required dialysis. R13's nutritional care plan dated 12/1/2021, included record and monitor intake daily, and weigh resident per facility protocol and monitor weights. The hydration care plan dated 1/7/2020, identified R13 was at risk for dehydration or potential fluid deficit related to regular loose stools; associated interventions included, educate resident/family on importance of fluid intake, offer drinks during one to one visits, ensure all beverages offered comply with diet/fluid restrictions and consistency requirements, monitor for signs of dehydration, and monitor and document intake and output as per facility policy. R13's care plan for hemodialysis dated 9/13/2019, directed the following: Check and change dressing daily at access site. Document. Check patency of the site as ordered, palpate the site to feel the thrill or use stethoscope to hear the whoosh or bruit of blood flow through the access, R13 received dialysis on Monday, Wednesday, and Fridays. If there is a major bleeding form site (post dialysis),	F 698	(MAR) and Care Plan was corrected to include breakdown of per 24-hour residents fluid restriction on 3/26/21. R 23 Medication administration record (MAR) and Care Plan was corrected to include breakdown of per 24-hour residents fluid restriction on 3/26/21. LPN-A was in serviced on the requirement to notify the Dialysis Center of any bleeding to Dialysis site post Dialysis treatment on 3/26/21. 2. Identification of other residents having the potential to be affected was accomplished by: Facility has no other residents on Dialysis. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed Nurses and TMA's will be in serviced on Facilities Dialysis resident process. This is including monitoring of Dialysis site, Fluid Restriction breakdown on MAR and Care Plan and Notification of post dialysis site bleeding by April 14-2021. Licensed Nurses and TMAs hired after April 14-2021 will be in serviced during orientation on this process. Facility implemented a new dialysis communication tool for improved communication between Facility and Dialysis center. DON/Designee will review residents Dialysis communication sheet during the following mornings clinical meeting. 4. How the corrective action(s) will be monitored to ensure the practice will not	

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F 698	Continued From page 80 apply pressure to insertion site and contact emergency services and dialysis center. This is a medical emergency. Do not leave resident alone until emergency services arrive. Monitor/document/report as needed for signs/symptoms of bleeding, hemorrhage, bacteremia, septic shock. Resident has an AV fistula on right upper arm, resident is on a 1.5 liter fluid restriction, and resident receives hemodialysis [name of dialysis clinic]. R13's physician orders included -Arginaid (nutritional supplement) 8 ounces (oz.) twice per day (start date 9/11/2019). -Please remove fistula bandages after 4 hours after each "Hb" (sic), if bleeding occurs, apply ten minutes pressure, then recheck. If bleeding still occurs, send patient to the ER every evening shift on Monday, Wednesday, Friday (start date 3/13/2020) -Check for presence of bruit/thrill- right arm every shift notify physician if absent (start date 2/28/2020) -Document dry weights when returning from dialysis obtain weight from dialysis (start date 2/12/2021) -Ensure resident has dialysis bag with dialysis supplies (start date 9/10/2020) -Fluid restriction 1500 ml (milliliters) per day. -Furosemide 40 mg (milligrams) two times a day (start date 8/29/2019). During an interview on 2/22/2021, at 6:37 p.m. R13 sat up in his wheelchair in his room. R13 stated he received dialysis on Monday, Wednesday, and Friday. R13 pointed to his right arm where his dialysis port was located; was a raised area on his shirt from underlying bandage	F 698	recur: DON/Designee will complete MAR audits 2 x week for one month then 1 x wk for two months for validation of appropriate fluid restriction documentation. Results of finding will be reviewed in QAPI monthly and compliance validated after 3 months.	

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F 698	Continued From page 81 (no bleeding observed through shirt). R13 stated staff had not checked the bandage for bleeding when he arrived back at the facility, and stated staff did not always check after the appointment. R13's progress note dated 1/5/2021 (Tuesday), at 1:39 p.m. included "When dressing removed from R [right] arm area this morning small amount of bright blood oozing from fistula. No blood on soiled dressing. Another dressing applied and when now removed no ne [sic] on dressing and is no longer bleeding. R13 record did not identify approximate amount of blood loss, how long the site was bleeding, how long pressure was applied, and lacked evidence of communication to the dialysis clinic. R13's progress note dated 1/6/2021, at 10:45 a.m. included, "No bleeding form fistula R arm prior to leaving for dialysis. No signs of bleeding after dressing removed yesterday." On 2/25/2021, at 8:29 a.m. surveyor contacted R13's dialysis clinic and obtained records from 1/6/2021. R13's dialysis note dated 1/6/2021, included "Patient reported fistula bleeding at nursing home. Patient stated it started yesterday after the staff took the gauze dressing off and that it bled a large amount and needed manual pressure held for a "long time". Unable to say how long. Gauze wrap was replaced and taken off this AM and patient reported it was still leaking some at this time. R13's dialysis communication notebook was reviewed from 1/4/2021 to 1/6/2021, no entries were made pertaining to R13's dialysis site bleeding.	F 698		

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F 698	Continued From page 82 During an interview on 2/25/2021, at 9:06 a.m. licensed practical nurse (LPN)-A stated she was the nurse working when R13's dialysis site was bleeding and wrote the progress note. LPN-A stated that morning she went in to check for bruit and thrill, there had not been a bandage on, and the site was dripping blood. LPN-A stated she applied a gauze pressure dressing to stop the bleeding, and when she came back there was only a small amount of blood on the dressing and the bleeding had stopped. LPN-A stated she thought she had rechecked the site after 30 minutes. LPN-A stated she had not notified dialysis of the bleeding because it was not a large amount and the bleeding stopped. During an interview on 2/25/2021, at 8:29 a.m. dialysis registered nurse (DRN) stated she was R13's care manager. DRN reviewed R13's visit notes dated 1/6/2021, and stated at the beginning of treatment patients are asked if they had any post bleeding issues; R13 was capable of telling us and was a reliable historian and knowledgeable when it came to his dialysis. DRN read the visit note aloud from 1/6/2021, and stated the facility had not communicated R13's site had post bleeding. DRN stated it would depend on the amount of bleeding if it was considered an emergency. DRN stated staff were supposed to apply pressure if they noted bleeding; stated the facility should have notified us of any bleeding either via phone or by writing it down it the communication book that goes back and forth. R13's January and February 2021 medication administration record (MAR) identified the	F 698		

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F 698	Continued From page 83 physician orders for the Arginaid; recorded fluid intake values ranged from 60 ml to 240 ml. R13's January and February 2021 treatment administration record (TAR) identified physician orders to check the fistula; the boxes had a check marked boxes indicating the task was completed on every dialysis day. The TARs also included the physician order for 1500 ml fluid restriction, however all of the boxes had an "X", with no fluid intake amount recorded. R13's record identified fluid intake was being recorded in two areas, "Meal intake" and "fluid intake". The recorded values were not consistent with each other, and the record lacked evidence of evaluation/assessment of R13's twenty-four hour intake. Examples include -Fluid intake documentation for 2/20/2021- the three boxes were blank; corresponding Meal intake for 2/20/21, indicated R13 consumed 240 ml for breakfast, lunch box was left blank, R13 consumed 240 ml for dinner. The MAR Arginaid consumption; R13 consumed 120 ml in the morning and evening. -Fluid intake documentation for 2/21/2021- two boxes were left blank and 3rd box had 240 ml recorded; corresponding Meal intake for 2/21/2021, had blank box for breakfast intake, lunch intake was 240 ml, and dinner intake was 120 ml. The MAR arginaid consumption was 120 ml in the morning and evening. -Fluid intake documentation for 2/22/2021, two boxes were left blank and two boxes had "0"; corresponding Meal intake for 2/22/2021, had 240 ml for breakfast, a blank box for lunch, and 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60	F 698		

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F 698	Continued From page 84	F 698		

ml in the evening.
-Fluid intake documentation for 2/23/2021, two boxes had "0" recorded and one box was blank; corresponding Meal intake for 2/23/2021, had blank box for breakfast, 240 ml for lunch, and 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening.

During an interview on 2/24/2021, at 2:31 p.m. registered nurse (RN)-B stated nurses are documenting fluid intake on the TAR's. RN-B reviewed the areas in R13's record where fluid intake was documented and stated it could not be determined how much fluid intake R13 consumed on a daily basis. RN-B stated the dietician would be a good person to evaluate daily fluid totals.

During an interview on 2/24/2021, at 2:38 p.m. NA-D stated dietary staff recorded fluid intake in the computer after they picked up meal trays.

During an interview on 2/24/2021, at 2:39 p.m. NA-J stated she used to work in dietary. NA-J stated dietary staff would record the amount of intake in the computer for each meal, if dietary staff did not have time on their shift, the next shift would record it for them. NA-J stated they did not record any other intake besides what the resident was provided with meals. NA-J indicated an unawareness of who was documenting the amount of fluid intake outside of meals.

During an interview on 2/25/2021, at 8:15 a.m. nursing assistant (NA)-I stated she was not sure if R13 was on a fluid restriction or not. NA-I stated NA's did not record fluid intake and that

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F 698	Continued From page 85 kitchen people tracked that. During an interview on 2/26/2021, at 8:51 a.m. trained medication assistant (TMA)-A stated when she passed medications she did not record the amount of fluid intake and dietary staff tracked fluid intake. During an interview on 2/26/2021, 9:18 a.m. RN-A stated if a resident was on a fluid restriction, the dietician determined how much fluid was divided over each meal, how much the resident could have in his room, and the amount allowed for medication passes. RN-A stated NA's were supposed to communicate to the nurse if the resident was requesting additional fluids outside of what they were provided. RN-A stated "I don't believe that there is someone evaluating the 24 hour totals, our dietician may go in but I can't confirm that." During an interview on 2/25/2021, at 11:22 a.m. director of nursing (DON) confirmed the record did not identify dialysis or provider was contacted when R13's dialysis site was bleeding, and they should have been and/or should have been in the dialysis communication book. DON indicated there should have been documentation of how/when the site was monitored for bleeding and expected staff check the site after dialysis according to physician orders. DON reviewed R13's fluid intakes and stated the facility did not have a solid way fluid intakes were being documented and evaluation of the intakes was not being completed. During an interview on 2/26/2021, at 9:39 a.m. certified dietary manager (CDM) stated dietary	F 698		

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F 698	Continued From page 86	F 698		

and housekeeping staff pass water twice per day, if a resident is on fluid restriction it is identified on a sheet of paper. CDM stated dietary staff are supposed to record fluid intake after each meal in the computer. CDM stated an unawareness of who was evaluating 24-hour daily fluid intakes. CDM stated an unawareness who was documenting fluid intake provided outside of meals such as fluids given during activities, during medication passes, or extra amounts the resident requests.

R23

R23's quarterly Minimum Data Set (MDS) assessment, dated 1/5/21, indicated the resident had moderately impaired cognition and required supervision with eating. The MDS further identified a diagnosis of end stage renal disease (ESRD), and received dialysis services.

R23's care plan, included a potential nutritional problem related to diet restriction for end stage renal disease and diabetes. Interventions included a 1500 cc (cubic centimeter) fluid restriction.

R23's active physician orders, included: Fluid restriction - 1200 cc's per day, with an order date of 1/19/21.

Review of R23's Medication Administration Record (MAR), and Treatment Administration Record (TAR) printed 2/25/21, and dated 2/1/21 - 2/28/21, did not include evidence of fluid monitoring by nursing staff.

R23's Dietary Card, printed 2/25/21, indicated:

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F 698	Continued From page 87 Fluid Restriction, 240 cc per meal. The undated form titled, Water Pass, provided by the dietary manager (DM), indicated R1 was on a 120 cc fluid restriction with each water pass. On 2/22/21, at 3:39 p.m. R23 confirmed being on a 1200 cc fluid restriction and stated, "But they bring me water whenever I ask for it". R23 was not sure if staff were tracking her fluid intake and shared one night had asked for water and the overnight staff gave her a large mug, "I told staff I didn't think I was supposed to have all that." On 2/24/21, at 12:14 p.m. R23 was observed in her room eating lunch. The meal included juice in an 8 ounce cup (240 cc) with a cover and straw. There were no other fluids included with the meal. On 2/25/21, at 1:22 p.m. activities aide (AA)-B confirmed activity staff could provide beverages at times for residents. AA-B stated there was only one resident she knew of that was on a fluid restriction; the resident was not R23. On 2/25/21, at 1:26 p.m., trained medication aide (TMA)-B stated to her knowledge, R23 was not on a fluid restriction. TMA-B confirmed when a resident was on a fluid restriction, nursing would monitor fluid intake with medications and dietary would monitor fluids consumed with meals and water pass. On 2/25/21, at 1:31 p.m. nursing assistant (NA)-H stated being unaware if R23 was on a fluid restriction as didn't work the east wing very much where R23 resided.	F 698		

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F 698	Continued From page 88 On 2/25/21, at 1:35 p.m. licensed practical nurse (LPN)-A stated to her knowledge, R23 was not on a fluid restriction. LPN-A further stated typically the dietary staff delegated and monitored what fluids were received by residents on a fluid restriction, and nursing would monitor fluids they administered on the MAR or TAR. LPN-A reviewed R23's physician orders and confirmed R23 was on a 1200 cc daily fluid restriction. When asked where nursing would document R23's fluid intake, LPN-A responded, "Good question". LPN-A reviewed R23's MAR and TAR and confirmed there was no tracking of fluid intake by nursing. On 2/25/21, at 1:43 pm. the dietary manager (DM) confirmed dietary staff were responsible for passing out water to residents and also for documenting how much water was consumed for residents on a fluid restriction. The staff that does the water pass has a sheet that indicated who was on a fluid restriction and how much they could receive. Dietary staff also tracked how much fluid was consumed at meals, and thought it was around 240 cc's at each meal, though if the resident requested more fluids than that staff couldn't refuse the resident's request. DM confirmed the dietician, who came to the facility weekly, was responsible for tracking fluid intake for resident's on a fluid restriction and would educate the resident if consuming more than prescribed. DM confirmed R23 was on a fluid restriction, and further confirmed the restriction was recently reduced from 1500 cc to 1200 cc daily. DM was unsure how nursing staff were notified when a resident was on a fluid restriction.	F 698		

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F 698	Continued From page 89 When interviewed on 2/25/21, at 3:36 p.m. the director of nursing (DON) confirmed staff should have been monitoring R23's fluid intake and that dietary staff's monitoring was not complete. DON further confirmed nursing should have been aware of R23's fluid restriction. When interviewed on 2/26/21, at 9:40 a.m. the DM confirmed dietary staff should be charting how much fluid was consumed for each meal and water pass. DM reviewed R23's fluid intake with meals and confirmed staff had not been consistently documenting how much fluid was consumed at each meal. A copy of R23's fluid intakes from 1/19/21 to 2/26/21 was requested but not received. Facility policy Hemodialysis Access Care dated 10/2010, included: Mild bleeding from the site (post dialysis) can be expected. Apply pressure to insertion site and contact dialysis center for instructions. If there is major bleeding from the site (post dialysis), apply pressure to insertion site and contact emergency services and dialysis center. Verify that clamps are closed on lumens. This is a medical emergency. Do not leave resident alone until emergency services arrive.	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		4/14/21

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F 755	Continued From page 90 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to dispose of a Fentanyl patch (a narcotic transdermal patch) in a manor to prevent diversion observed during medication review. Findings include: R18's current physician orders signed 2/8/21, included: Fentanyl patch 72 hour 12 mcg/hr (micrograms per hour). Apply one patch	F 755	1. Immediate action(s) taken for the resident(s) found to have been affected include: (TMA)-A was reeducated on the requirement to have a Licensed Nurse witness and sign for the controlled substance destruction of a Fentanyl Patch and placed in a drug buster located in the medication room on 2/26/21. 2. Identification of other residents having	

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F 755	Continued From page 91 transdermally every 72 hours for chronic pain place on the skin every third day an remove per schedule. On 2/26/21, at 11:15 a.m. trained medication aide (TMA)-A was observed reconciling R18's Fentanyl patches by counting the patches then checking the count against the narcotic ledger book for the east wing. TMA-A confirmed the process for destroying Fentanyl patches was to fold the patch in half and dispose of in the drug buster in the medication room while evidenced by a nurse. The nurse and TMA would then sign off the destruction on the electronic medication administration record (eMAR). It was noted that the last Fentanyl patch administered to R18 on 2/25/21 was charted in the eMAR as removed but was not charted as destroyed with evidence from a licensed nurse. TMA-A consulted with licensed practical nurse (LPN)-A who had worked the day shift on 2/25/21, and would have evidenced the Fentanyl patch being destroyed. LPN-A confirmed TMA-B had administered medications for the east wing on 2/25/21, though had not brought a Fentanyl patch to the medication room that day to be destroyed. When interviewed on 2/26/21, at 11:28 a.m. TMA-B confirmed having removed R18's Fentanyl patch on 2/25/21, prior to applying a new patch. TMA-B stated she folded the patch in half, then placed in a sharps container unwitnessed. TMA-B denied knowledge that Fentanyl patches were to be destroyed in the mediation room in the drug buster with a licensed nurse. The director of nursing (DON) was present during the interview and confirmed 2 staff should be signing off destruction of the Fentanyl	F 755	the potential to be affected was accomplished by: Current residents receiving Fentanyl Patches reviewed for the past thirty days for appropriate documented destruction. No other residents found to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Facilities TMA□s and Licensed nurse will be in serviced on the facility practice to destroy controlled substances in the presence of a Licensed Nurse and for the Licensed Nurse cosign the destruction. Fentanyl patches will be destroyed per manufacture's guidelines by April 14-2021. TMAs and Licensed nurse hired after April 14-2021 will be in serviced during orientation on this process. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON/Designee will complete random audits of the EMAR 2 x week for one month then 1 x wk for two months for validation the medication destruction is cosigned. Results of finding will be reviewed in QAPI monthly and compliance validated after 3 months. Corrective action completion date: ____04/14/2021_____.	

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F 755	Continued From page 92 patches though was unaware disposal in a sharps container was no longer acceptable. A policy on Fentanyl patch destruction was requested but not received.	F 755		
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 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		4/14/21

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F 758	Continued From page 93 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a comprehensive sleep assessment to determine the need for sleep aids ordered for insomnia for 1 of 5 residents (R12) reviewed for unnecessary medications. Findings include: R12's admission record revealed R12 was admitted on 9/27/20 with diagnoses of dementia with behavioral disturbance, anxiety and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 11-30-20, indicated R12 did not display behavior problems or difficulty sleeping, feeling tired or having little energy. R12's physician orders included Trazodone 50 MG (milligrams) Give 1 tablet by mouth at bedtime for insomnia/restlessness. The start date	F 758	1. Immediate action(s) taken for the resident(s) found to have been affected include: R 138 had a sleep log initiated upon admission 2/25/21 – 3/17/21 2. Identification of other residents having the potential to be affected was accomplished by: Current resident with sleep medication reviewed for a current sleep log. No other residents found not to have a sleep study completed in the past quarter. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed Nurses will be in serviced on the facility practice to have a sleep log completed on new/re admissions, quarterly, annually and with significant change for long term residents prescribed	

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F 758	Continued From page 94 for this order was 10/29/2018. R12's care plan did not include non-pharmacological interventions for sleep. R12's medical record lacked evidence of a comprehensive sleep assessment and analysis of sleep monitoring for continued use of Trazodone. R12s physician visit progress note dated 2/1/2021 included," The patient is a pleasant 92-year-old woman, I am seeing for a routine visit ...denies depression, appetite or sleep problems ..." During an interview on 2/25/21, at 9:03 a.m. the director of nursing (DON) stated she was unable to locate sleep monitoring or a sleep assessment for R12. The DON verified a sleep assessment was completed to help determine justification for continued use of the medication. During an interview on 2/02/25/21, at 5:17 p.m. registered nurse (RN)-A stated sleep assessments would be documented under assessments and if was unable to find one there, would assume a sleep assessment had not been done. RN-A stated sleep assessments should be completed quarterly, annually, with a change of condition and change of sleep. A policy and procedure for sleep assessments was requested and not provided.	F 758	a sleep medication by April 14-2021. Licensed Nurses hired after April 14-2021 will be in serviced during orientation on this process. DON/Designee will validate new / re admissions receiving sleep medication have a sleep log initiated during the next morning clinical meeting. DON/Designee will validate during quarterly, annual, and significant change care assessment that of residents that are receiving scheduled sleep medication for insomnia have had a sleep log and MD notified of results. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON/Designee newly ordered sleep medication 2 x week for one month then 1 x wk for two months for appropriate initiation and completion of sleep log and physician notification of log results.. Results of finding will be reviewed in QAPI monthly and compliance validated after 3 months.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F 759		4/14/21

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F 759	Continued From page 95 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 7.69% percent with 2 errors out of 26 opportunities for error involving 1 of 7 residents (R11) who were observed during the medication pass. Findings include: R11's Admission Record (face sheet), indicated R11 had diagnoses including unspecified convulsions and anxiety disorder. R11's Order Summary Report (physician's orders), included orders for Tegretol (carbamazepine) (an anticonvulsant medication used to treat seizure disorders) 200 milligrams (mg) give 1 tablet by mouth three times a day, fish oil 1000 mg give one capsule by mouth two times a day, gabapentin (an anticonvulsant medication also used to treat nerve pain) 100 mg give 2 capsules by mouth two times a day, magnesium oxide give 400 mg by mouth in the morning, multiple vitamin give one tablet by mouth in the morning, and paroxetine HCl (an antidepressant medication) 20 mg give 40 mg by mouth in the morning. On 2/24/21, at 8:03 a.m. trained medication aide (TMA)-B was observed setting up medications for	F 759	1. Immediate action(s) taken for the resident(s) found to have been affected include: R 11 did not receive any medication not prescribed. (TMA)B was reeducated on the rights of medication delivery and had a medication pass competency completed on 2/26/21. TMA-B was removed from the TMA role 2. Identification of other residents having the potential to be affected was accomplished by: Current residents receiving medication by a TMA potential could have been affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Facilities TMA's will be in serviced on the rights of medication delivery and have a medication pass observation completed by April 14-2021. TMAs hired after April 14-2021 will be in serviced during orientation on this process. TMAs will have medication pass observations no less than biannual. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON/Designee will complete random medication pass audits 2 x week for one month then 1 x wk for two months for validation of rights of medication delivery	

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F 759	Continued From page 96 R11 in the following order: gabapentin 100 mg-2 tablets, Tegretol 200 mg, fish oil 1000 mg, magnesium oxide 400 mg, and multiple vitamin-1 tablet. After dishing up the multiple vitamin, TMA-A obtained a medication in a blister package (a packing design consisting of pre-formed plastic attached to a backing or that folds together to form a seal). TMA-B pushed one of the tablets out of the blister package, then handed the package to the surveyor to review. The medication was Tegretol 200 mg give one tablet by mouth three times a day and had a blue sticker on it that read, "Bedtime". Surveyor brought to TMA-B's attention that she had already dished up R11's morning Tegretol dose and that this was the bedtime dose. TMA-B removed the Tegretol tablet from the medication cup, then obtained another different medication blister package and pushed one of the tablets out of the blister package into the medication cup, then handed the package to the surveyor to review. The medication was Tegretol 200 mg by mouth three times a day. Again, surveyor pointed out to TMA-B that she had already dished up that medication. TMA-B then again removed the extra dose of Tegretol from the med cup. TMA-B stated it was supposed to be Tegretol 20 mg but couldn't find a 20 mg tablet. Surveyor asked TMA-A to show the surveyor the physician order on the computer for the medication she was trying to find. TMA-B pointed out the order; the medication was paroxetine 40 mg by mouth in the morning. Surveyor advised TMA-B that it was a different medication than Tegretol; TMA-B then found the correct medication in the med cart and placed into the med cup.	F 759	are being followed. Results of finding will be reviewed in QAPI monthly and compliance validated after 3 months.	

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F 759	Continued From page 97 The policy titled, Administering Medications, revised 11/28/20, indicated: 6. The individual administering the medication must check the label to verify the right medication, right dosage, right time and right method of administration before giving the medication.	F 759		
F 761 SS=D	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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 2 of 2	F 761	1. Immediate action(s) taken for the resident(s) found to have been affected	4/14/21

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F 761	Continued From page 98 treatment carts and 1 of 3 medication carts were locked when not in use. Findings included: On 2/24/21, at 8:30 a.m. the top drawer of the south treatment cart was observed unlocked with no staff present. At 8:31 a.m. trained medication aide (TMA)-C approached the treatment cart and confirmed the top drawer was unlocked and shouldn't have been. The top drawer of the cart contained 24 lotions and ointments, 2 ketoconazole prescription shampoo and 2 nystatin powder, prescribed for 10 different residents. On 2/24/21, at 8:32 a.m. the top drawer of the east treatment cart was observed unlocked. The top drawer of the cart contained several prescription lotions, ointments and powders. TMA-B was standing at the medication cart with her back to the treatment cart and was setting up medications. At 8:37 a.m. TMA-B walked away from the carts to administer medication. TMA-B locked the medication cart but not the treatment cart. At 8:39 a.m., TMA-B returned to the area when the medication and treatment carts were stored. TMA-B confirmed the top drawer of the treatment cart was unlocked and shouldn't have been. TMA-B attempted to lock the top drawer; the locking mechanism wasn't functioning properly making it unable to secure the cart. TMA-B stated she would let maintence know but did not move the prescribed lotions, ointments and powders to a secured location. When interviewed on 2/24/21, at 1:20 p.m. the director of nursing (DON) stated she would	F 761	include: (TMA)-B was reeducated on the requirement to keep the medication and treatment cart locked when not in reach on 2/24/21. (TMA)-C was reeducated on the requirement to keep the medication and treatment cart locked when not in reach on 2/24/21. 2. Identification of other residents having the potential to be affected was accomplished by: Current residents receiving medication by a TMA potential could have been affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: TMA's will be in serviced on the requirement to keep the medication and treatment carts completed by April 14-2021. TMAs hired after April 14-2021 will be in serviced during orientation on this process. Pharmacy to have new treatment carts replaced by April 14-2021. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON/Designee will complete random observations of the treatment and medication carts audits 2 x week for one month then 1 x wk for two months for validation they are appropriate secured. Results of finding will be reviewed in QAPI monthly and compliance validated after 3 months.	

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F 761	Continued From page 99 expect the treatment and medication carts to be locked and secured at all times when not in use. On 2/26/2, at 11:15 a.m. the east medication cart was observed unlocked. Approximately two minutes later TMA-A arrived and confirmed the cart was unlocked and shouldn't have been. The policy titled, Administering Medications, revised 11/28/20, indicated: 9. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national	F 880		4/14/21

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F 880	Continued From page 100 standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 101 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 by ensuring staff utilized appropriate personal protective equipment (PPE) precautions, including the use of gowns, when providing direct care to residents newly admitted/re-admitted to the facility during their 14-day quarantine for 3 of 3 residents (R 138, R139, R137) observed. in addition, the facility failed to ensure new admission presumed positive residents were quarantined in their room for 14-days for 1 of 1 residents (R139) who attended the group resident council meeting. The facility also failed to ensure proper infection control technique while administering medication for 1 of 7 residents (R11) observed during medication administration. Findings include: R138's face sheet, identified an admission date to facility on 2/12/2021, with diagnoses that included obstructive sleep apnea and ventral hernia with gangrene. R138's hospital discharge summary, indicated during R138's hospital course he developed and treatment was started for ventilator associated pneumonia. The summary indicated upon discharge from the hospital R138 was "noted to	F 880	1. Immediate action(s) taken for the resident(s) found to have been affected include: R 138 was discharged on 3/16/2021. R 139 is no longer on new admission quarantine. R 137 is no longer on new admission quarantine. (TMA)-B was reeducated, and a medication pass observation completed on 3/26/21. RN-A was reeducated on appropriate PPE for residents on isolation on 2/26/21. (NA)-E was reeducated on appropriate PPE for residents on isolation on 2/26/21. 2. Identification of other residents having the potential to be affected was accomplished by: Current review of residents that had been admitted/Readmitted within the past 14 day had appropriate signage for Infection precaution outside their room door and required PPE outside their rooms available for staff. Medication Pass observation for proper handling of medication completed with current facility TMA□s. No other observation of failed infection control practice found.	

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F 880	Continued From page 102 have expiratory wheezes to auscultation.", chest X-ray showed persistent bilateral airspace opacities with some progression in the left lower lobe, possible pneumonia. During an observation on 2/22/2021, at 3:07 p.m. R138's room did not have signage or personal protective equipment (PPE) outside of his room that would identify R138's required transmission based precautions. R138 was observed to be sitting in his recliner in his room. During an observation on 2/22/2021, at 4:10 p.m. R138 sat in his recliner in his room. R138 stated he was going to call 911 for his cough. R138 coughed (dry non-productive, covered his mouth). Nursing assistant (NA)-E stood next to R138; NA-E wore a face mask and eyes shield but did not have a gown on. NA-E attempted to redirect R138 from calling 911. NA-E washed and sanitized her hands before she exited R138's room. During an observation and interview on 2/22/2021, at 4:15 p.m. registered nurse (RN)-A entered R138's room with a face shield and a mask on; RN-A did not have a gown on. RN-A indicated R138 had been admitted from the hospital and had been treated in the hospital for respiratory illness not related to COVID-19 and had a dry cough intermittently since admission. RN-A indicated R138 was quarantined related to new hospital admission, confirmed there was not signage or PPE outside of R138's room. R139 R139's face sheet, identified an admission date to facility of 2/20/21 with diagnoses including	F 880	3. Actions taken/systems put into place to reduce the risk of future occurrence include: Facility s staff will be in serviced by April 14-2021 on appropriate PPE usage by Isolation Precautions. Facility staff hired after April 14-2021 will be in serviced during Orientation on appropriate PPE usage by Isolation precautions. Facilities Licensed nurse will be in serviced by April 14-2021 on appropriate isolation signage and PPE availability outside of resident□s room for new admissions. Licensed Nurses hired after April 14-2021 will be in serviced during Orientation on appropriate isolation signage and PPE availability outside of resident□s room for new admissions. Facilities TMA□s will have a medication pass Infection control reeducation and an observation completed by April 14-2021. TMAs hired after April 14-2021 will have medication pass Infection control education and an observation completed during Orientation. DON/Designee will validate new /readmission residents isolation precaution signage and PPE outside of the room is present prior to resident□s arrival to the facility. DON/Designee will complete Medication pass observations for TMAs on a minimum of a biannual basis. 4. How the corrective action(s) will be monitored to ensure the practice will not recur:	

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F 880	Continued From page 103 diabetes and chronic obstructive pulmonary disease. R139's hospital discharge summary dated 2/19/2021, indicated R139's tested negative for Covid-19 on 2/19/2021. The summary did not include why R139 was tested for COVID-19. During an observation and interview on 2/22/2021, at 3:30 p.m. R139's room did not have signage or PPE outside of his room. R139 sat in his bed. R139 stated he had just been admitted to the facility a couple of days ago; facility staff had informed him he was supposed to be quarantined for a while and had been only been out of his room to get weighed. R139 was not observed to have respiratory symptoms. During an observation on 2/23/2021, at 8:52 a.m. RN-A and director of nursing (DON) were in R139's room; both wore a face mask and face shield however did not have a gown on. RN-A changed R139's groin dressing. R139 was not observed to have respiratory symptoms. R137 R137's face sheet, identified an admission date to facility of 2/12/21 with diagnoses including altered mental state and avoidant personality disorder. During an observation and interview on 2/22/2021, at 4:27 p.m. R137's room did not have signage or PPE outside of her room. R137 stated she had been admitted to the facility almost two weeks ago. R137 was not observed to have respiratory symptoms.	F 880	DON/Designee will audit new admissions 2x/week for one month then 1 x wk for two months for appropriate isolation precaution signage and PPE outside of the room. DON/Designee will complete one TMA random Medication pass observation 2x/week for one month then 1 x wk for two months for appropriate infection control practices. Results of finding will be reviewed in QAPI monthly and compliance validated after 3 months.	

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F 880	Continued From page 104 During an interview on 2/23/2021, at 4:06 p.m. NA-H indicated that the one hallway was where the facility put residents who came from the hospital and those residents were on quarantine, (R137, R138, and R139). NA-H stated we have not ever been required to wear gowns for hospital admissions, only masks and face shields. NA-H confirmed that there was no signage or PPE stations down that hallway or in front of the residents rooms, and if you were not an employee of the facility you would have to ask the nurse to find out if there were any special precautions. NA-H stated R137 and R139 have not had any symptoms, and R138 had been admitted with a dry cough that would come and go; stated it was something else besides COVID-19. During an interview on 2/23/2021, at 4:11 p.m. licensed practical nurse (LPN)-B confirmed that there was not PPE stations or signage in front of the resident's rooms that were on quarantine related to hospital admissions. LPN- indicated if there was a cause of concern, then gowns should be worn. When interviewed on 2/23/21, at 3:15 p.m. the director of nursing (DON) confirmed all residents that are admitted or re-admitted from the hospital into the facility need a negative Covid-19 test and are quarantined to their room for 14 days. DON stated at the last facility she worked at the staff utilizing full PPE when entering the room of a resident on quarantine and confirmed at this facility staff had not been utilizing gowns when entering quarantined resident rooms. DON was unsure how many gowns were on hand at the	F 880		

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F 880	Continued From page 105 facility. When interviewed on 2/23/21, at 4:36 p.m. DON confirmed the facility had 8 cases of gowns in storage and would be initiating droplet precautions including the use of gowns immediately for the new and re-admitted residents. The policy titled COVID-19, revised 6/1/20, indicated: Persons Under Investigation (PUI)/ suspected covid in the facility. As a precautionary measure, any suspected cases will be handled as follows: Use standard precautions, contact precautions, and eye protection, and a mask...Precaution signs will be placed on the door. R11 medication administration R11's Admission Record (face sheet), indicated R11 had diagnoses including unspecified convulsions and anxiety disorder. R11's Order Summary Report (physician's orders) signed 2/25/21, included orders for Tegretol (carbamazepine) (an anticonvulsant medication used to treat seizure disorders) 200 milligrams (mg) give 1 tablet by mouth three times a day, fish oil 1000 mg give one capsule by mouth two times a day, gabapentin (an anticonvulsant medication also used to treat nerve pain) 100 mg give 2 capsules by mouth two times a day, magnesium oxide give 400 mg by mouth in the morning, multiple vitamin give one tablet by mouth in the morning, and paroxetine HCl (an antidepressant medication) 20 mg give 40 mg by mouth in the morning.	F 880		

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F 880	Continued From page 106 On 2/24/21, at 8:03 a.m. trained medication aide (TMA)-B was observed setting up medications for R11 in the following order: gabapentin 100 mg-2 tablets, Tegretol 200 mg, fish oil 1000 mg, magnesium oxide 400 mg, and multiple vitamin-1 tablet. After dishing up the multiple vitamin, TMA-A obtained a medication in a blister package (a packing design consisting of pre-formed plastic attached to a backing or that folds together to form a seal). TMA-B pushed one of the tablets out of the blister package, then handed the package to the surveyor to review. The medication was Tegretol 200 mg give one tablet by mouth three times a day and had a blue sticker on it that read, "Bedtime". Surveyor brought to TMA-B's attention that she had already dished up R11's morning Tegretol dose and that this was the bedtime dose. TMA-B removed the Tegretol tablet from the medication cup with her bare hands, then replaced the medication back into the blister package. TMA-A then obtained a different medication blister package and pushed one of the tablets out of the blister package into the medication cup, then handed the package to the surveyor to review. The medication was Tegretol 200 mg by mouth three times a day. Again, surveyor pointed out to TMA-B that she had already dished up that medication. TMA-B again removed the extra dose of Tegretol from the med cup with her bare hands, then replaced the medication back into the blister package. When interviewed on 2/24/21, at 8:19 a.m. TMA-B confirmed it was the facilities practice to tape medications back into the blister pack if punched out by mistake. TMA-B further	F 880		

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F 880	Continued From page 107 confirmed it was ok to use her bare hands to remove the medications from the med cup as she utilized the hand sanitizer so much that it's ok. When interviewed on 2/24/21, at 1:20 p.m. the director of nursing (DON) stated she would expect the TMA or nurse doing medication administration to discard a medication if it was popped out of a blister package in error, and not place it back into the blister package with tape on the back. DON further confirmed staff should not be touching medications with their bare hands as this was an infection control concern. The policy titled, Administering Medications, revised 11/28/20, indicated: Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications. RESIDENT COUNCIL MEETING R139's face sheet, identified an admission date to facility of 2/20/21 with diagnoses including diabetes and chronic obstructive pulmonary disease. R139 attended the facility resident council meeting held during the survey on 2/23/21, at 10:00 a.m. R139 was a new admission to the facility and should have been on 14 day presumed positive quarantine. During an interview on 2/25/21, at 9:12 a.m. the director of nursing (DON) stated the ombudsman gave her the names of the residents who attended the resident council meeting and she immediately said R139 should not have attended	F 880		

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F 880	Continued From page 108 as he was a new admission and was presumed positive and was on quarantine. The DON stated every new admission to the facility was on presumed positive 14-day quarantine and stated the 400 hall was the facility quarantine hall. The DON stated the activity director (AD) was aware R139 was on a quarantine hall and stated in her defense we did not have anything posted to indicate the residents on the 400 hall were in quarantine. The DON stated presumed positive residents were to stay in their rooms for 14 days. During an interview on 2/25/21, at 11:39 a.m. the AD stated there was a misunderstanding between her and admission coordinator (AC). The AD stated she asked the AC if R139 could participate in the resident council meeting because he was on quarantine and AC stated it was fine as she thought interviews would be completed in individual rooms.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		4/14/21

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F 883	Continued From page 109 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced	F 883		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 110 by: Based on interview and document review the facility failed to provide evidence influenza vaccinations were up to date for 3 of 5 residents (R18, R23, R31) and pneumococcal vaccinations were up to date for 2 of 5 residents (R18, R31) reviewed for vaccinations. Findings include: R18's Admission Minimum Data Set (MDS) assessment dated 1/13/21, indicated an admission date of 1/5/21. The MDS did not indicate whether R18 was current on her influenza and pneumococcal vaccinations nor did it indicate if the resident had been offered and declined the vaccinations. Further review of R18's medical record did not include evidence an influenza or pneumococcal vaccination had been offered or received. R23's quarterly MDS dated 1/5/21, indicated an admission date of 9/16/20. The MDS indicated R23 was not current on her influenza vaccination but did not indicate a reason why or if the vaccination had been offered and declined. Further review of R23's medical record did not include evidence an influenza vaccination had been offered. R31's quarterly MDS dated 1/29/21, indicated an admission date of 10/16/20. The MDS did not indicate whether R31 was current on her influenza vaccination nor did it indicate if the resident had been offered and declined the vaccination. The MDS further indicated R31 was not up to date on her pneumococcal vaccinations but did not indicate a reason why or if the	F 883	1. Immediate action(s) taken for the resident(s) found to have been affected include: R18 Influenza consent completed on 3/26/21. Resident declined vaccine. Pneumococcal consent completed on 3/26/21. Resident declined vaccine. R23 Influenza consent completed on 3/26/21. Resident declined vaccine. Pneumococcal consent completed on 3/26/21. Resident declined vaccine. R31 Influenza consent completed on 10/15/20. POA accepted vaccine. Vaccine 3/26/21. Pneumococcal consent completed on 10/15/20. POA accepted vaccine. Vaccine administered on 3/26/21. 2. Identification of other residents having the potential to be affected was accomplished by: Current residents records audit for both Influenza and Pneumococcal consents.12 other resident found without consent. Current residents MDS reviewed, 12 residents found without MDS immunization documentation. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Director of Nursing (DON) /Designee will monitor for completion of Influenza consent completion and submission on the MDS until April 1,2020. MDS Coordinator/Unit Manger will be educated on completing the vaccine	

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	245499	A. BUILDING _____ B. WING _____	C 02/26/2021

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F 883	Continued From page 111 vaccination had been offered and declined. Further review of R18's medical record did not include evidence an influenza or pneumococcal vaccination had been offered or received. When interviewed, the director of nursing (DON) confirmed finding no evidence in R18 and R31's medical record that influenza or pneumococcal vaccinations had been offered or received, and no evidence in R23's medical record that an influenza vaccination had been offered or received. A policy on immunizations for residents was requested but not received.	F 883	sections of the MDS by April 14,2021. The new MDS coordinator will be in serviced during orientation on the requirement of completing the Vaccines section of the MDS. Licensed nursing staff will be in service on completing the Pneumococcal consent during the admission process by April 14-2021. Licensed nurses hired after April 14-2021 will be in serviced during orientation on this process. Facility nurses will be in serviced in September of 2021 on the requirement to complete the Influenza consent for current residents and residents with the admission process. DON/Designee will review residents' chart in morning clinical meeting for completed Pneumococcal Consents. DON/Designee will review the MDS immunization section prior to the MDS submission. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON/Designee will audit new admission charts 2x/week for one month then 1 x wk for two months for completed Pneumococcal consents. DON/Designee will audit MDS submissions for 2x/week for one month then 1 x wk for two months for completed Immunization section. Results of finding will be reviewed in QAPI monthly and compliance validated after 3 months.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 19, 2021

Administrator
Caledonia Rehabilitation & Retirement Center
425 North Badger Street
Caledonia, MN 55921

Re: State Nursing Home Licensing Orders
Event ID: TVJH11

Dear Administrator:

The above facility was surveyed on February 22, 2021 through February 26, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/22/21 through 2/26/2021 a survey was conducted to determine compliance for State Licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 In addition, complaint investigations were also completed at the time of the licensing survey. The following complaints were found to be UNSUBSTANTIATED: H5499044C (MN63661) The following complaints were found to be SUBSTANTIATED with no licensing orders: H5499042C (MN62507) H5499043C (MN69239) The following complaints were found to be SUBSTANTIATED with deficiencies: H5499041C (MN62263), licensing oders issued at 0685 and 1325 H5499040C (MN56088), citation issued at 0830	2 000		
2 475	MN Rule 4658.0260 Subp. 3 Personal Fund Accounting and Records Subp. 3. Accounting system. A nursing home must establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing home on the resident's behalf. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide quarterly statements for resident fund accounts for 4 of 4 residents (R10, R12, R28, R138) reviewed. In addition, the facility failed to maintain a separate accounting of each resident's funds and failed to follow	2 475	Corrected.	4/14/21

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2 475	Continued From page 2 accounting principles for the accounts. This affected all 12 residents who had resident fund accounts overseen by the facility. Findings include: During an interview on 2/22/21, at 6:51 p.m. R10 stated they had not received a quarterly statement from the facility. During an interview on 02/25/21, at 11:21 a.m. the business office manager (BOM) stated R10 had a personal trust account with the facility and indicated R10 was admitted 7/2/2020. The BOM stated the personal funds statements were to be sent out on a quarterly statement. The BOM stated the previous BOM's last day at the facility was the 1/16/21 and indicated she had been unable to determine the last time the previous BOM had sent out quarterly statements. During an interview on 02/25/21, at 12:25 p.m. the administrator and BOM stated they identified last week quarterly statements were not being sent to residents. The administrator and BOM stated the previous person had indicated they were behind on sending out quarterly statements and stated they had been unable to find any records of when last quarterly statements were sent out to residents. The BOM stated 12 current resident had trust accounts and the facility was unable to determine at this time how much money was in each resident account. The BOM stated she was planning to go to the bank to get the deposit slips to figure out how much money was in each account from the bank documentation of deposits. The BOM stated the resident funds were kept in a checking account rather than a saving account. The BOM stated	2 475		

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2 475	Continued From page 3 the bank was going to work with her to get money transferred into an interest- bearing account and stated she talked to the bank about that this afternoon. A policy on personal funds accounts was requested and not provided. SUGGESTED METHOD OF CORRECTION: The business office manager (BOM) or designee could review any policies, procedures or facility processes for resident funds including account balance and make any necessary revisions. Appropriate staff could be educated regarding any changes. The BOM or designee could develop a system to monitor for on-going compliance and report results to the quality improvement committee for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one Days	2 475		
2 480	MN Rule 4658.0260 Subp. 4 Personal Fund Accounting and Records Subp. 4. Financial record. The resident's financial record must be available through quarterly statements and on request to the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide quarterly statements for resident fund accounts for 4 of 4 residents (R10, R12, R28, R138) reviewed. In addition, the facility failed to maintain a separate accounting of	2 480	Corrected.	4/14/21

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2 480	Continued From page 4 each resident's funds and failed to follow accounting principles for the accounts. This affected all 12 residents who had resident fund accounts overseen by the facility. Findings include: During an interview on 2/22/21, at 6:51 p.m. R10 stated they had not received a quarterly statement from the facility. During an interview on 02/25/21, at 11:21 a.m. the business office manager (BOM) stated R10 had a personal trust account with the facility and indicated R10 was admitted 7/2/2020. The BOM stated the personal funds statements were to be sent out on a quarterly statement. The BOM stated the previous BOM's last day at the facility was the 1/16/21 and indicated she had been unable to determine the last time the previous BOM had sent out quarterly statements. During an interview on 02/25/21, at 12:25 p.m. the administrator and BOM stated they identified last week quarterly statements were not being sent to residents. The administrator and BOM stated the previous person had indicated they were behind on sending out quarterly statements and stated they had been unable to find any records of when last quarterly statements were sent out to residents. The BOM stated 12 current resident had trust accounts and the facility was unable to determine at this time how much money was in each resident account. The BOM stated she was planning to go to the bank to get the deposit slips to figure out how much money was in each account from the bank documentation of deposits. The BOM stated the resident funds were kept in a checking account	2 480		

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2 480	Continued From page 5 rather than a saving account. The BOM stated the bank was going to work with her to get money transferred into an interest- bearing account and stated she talked to the bank about that this afternoon. A policy on personal funds accounts was requested and not provided. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could create policies and procedures related to financial management of resident accounts to ensure quarterly statements are provided to residents. Quality assurance committee could audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 480		
2 485	MN Rule 4658.0265 Deposit of Personal Funds A nursing home, except for veterans homes under Minnesota Statutes, section 198.265, must deposit a resident's personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the nursing home's operating accounts, and that credits all interest earned on the resident's account to the resident's account. Pooled accounts must separately account for each resident's share. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide quarterly statements for resident fund accounts for 4 of 4 residents (R10, R12, R28, R138) reviewed. In addition, the facility failed to maintain a separate accounting of	2 485	Corrected.	4/14/21

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2 485	Continued From page 6 each resident's funds and failed to follow accounting principles for the accounts. This affected all 12 residents who had resident fund accounts overseen by the facility. Findings include: During an interview on 2/22/21, at 6:51 p.m. R10 stated they had not received a quarterly statement from the facility. During an interview on 02/25/21, at 11:21 a.m. the business office manager (BOM) stated R10 had a personal trust account with the facility and indicated R10 was admitted 7/2/2020. The BOM stated the personal funds statements were to be sent out on a quarterly statement. The BOM stated the previous BOM's last day at the facility was the 1/16/21 and indicated she had been unable to determine the last time the previous BOM had sent out quarterly statements. During an interview on 02/25/21, at 12:25 p.m. the administrator and BOM stated they identified last week quarterly statements were not being sent to residents. The administrator and BOM stated the previous person had indicated they were behind on sending out quarterly statements and stated they had been unable to find any records of when last quarterly statements were sent out to residents. The BOM stated 12 current resident had trust accounts and the facility was unable to determine at this time how much money was in each resident account. The BOM stated she was planning to go to the bank to get the deposit slips to figure out how much money was in each account from the bank documentation of deposits. The BOM stated the resident funds were kept in a checking account	2 485		

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2 485	Continued From page 7 rather than a saving account. The BOM stated the bank was going to work with her to get money transferred into an interest- bearing account and stated she talked to the bank about that this afternoon. A policy on personal funds accounts was requested and not provided. SUGGESTED METHOD OF CORRECTION: The administrator could educate accounting staff that interest on personal funds is a requirement. A system could be developed to audit the financial records to ensure interest is earned for personal fund accounts. The result of this could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 485		
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete a comprehensive discharge summary for 1 of 1 resident (R36) reviewed for discharge. Findings include:	2 685	Corrected.	4/14/21

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2 685	Continued From page 8 R36's face sheet, identified an admission date to facility of 11/30/20 with diagnoses including hypertension (high blood pressure), personal history of diabetic foot ulcer and diabetes. Review of R36's discharge instructions dated 12/16/20, indicated R36 discharged to the [name of Hotel], would have Home Services and listed the company that would provide services. The discharge instructions further indicated written, and verbal education was completed by reviewing the medication administration record (MAR) and treatment administration record (TAR) with R36. The discharge instructions provided were not signed by the resident or family and did not include copies of medications, MAR, or TAR. R36's discharge instructions did not include cognitive patterns, communication, vision, mood behavior patterns, psychosocial well-being, continence, diagnosis and health conditions, skin condition, and activity pursuit. During an interview on 2/25/21, at 8:43 a.m. the receptionist stated was unable to find a copy of R36's signed discharge instructions and information provided to R36 upon discharge from the facility. During an interview on 02/25/21, at 8:45 a.m. the director of nursing (DON) verified R36's discharge instructions did not include cognitive patterns, communication, vision, mood behavior patterns, psychosocial well-being, continence, diagnosis and health conditions, skin condition, and activity pursuit. The DON stated the management company was in the process of building a discharge summary for the facility to complete. The DON verified R36's discharge	2 685		

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2 685	Continued From page 9 instructions did not meet the requirements of the regulation. The Transfer and Discharge (including AMA[against medical advice]) policy dated 2020 included, Anticipated Transfers or Discharges-initiated by the resident. Obtain physician's orders for transfer or discharge and instructions or precautions for ongoing care. A member of the interdisciplinary team completes relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to the following: A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy. And pertinent lab radiology and consultation results. A final summary of the resident's status. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter.) A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment. Orientation for transfer or Discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team. Assist with transportation arrangements to the new facility and any other arrangements as needed.	2 685		

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2 685	Continued From page 10 The comprehensive, person-centered care plan shall contain the resident's goal for admission and desired outcomes and shall be in alignment with the discharge. Supporting documentation shall include evidence of the resident's or resident's representative's verbal or written notice of the intent to leave the facility, a discharge plan, and documented discussions with the resident and/or resident representative. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures regarding discharge summary. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 685		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		4/14/21

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2 830	Continued From page 11 This MN Requirement is not met as evidenced by: FALLS Based on observation, interview and document review, the facility failed to comprehensively assess each fall, identify causative factors to determine the reason for falls and identify potential effective interventions to decrease the risk for future falls for 2 of 2 residents (R137, R24) reviewed for accidents. Findings include: R137 was observed on 02/23/21, at 3:32 p.m. sitting on the side of her bed, gripper socks, tray table in front of her. R137's face sheet, identified an admission date to facility of 2/12/21 with diagnoses including altered mental status, avoidant personality disorder, diabetes and borderline personality disorder. R137's Fall Risk Assessment dated 2/15/21 indicated R137 was at moderate risk for fall with a score of 13. R137's fall care plan included, "I am at risk for falls r/t [related due] deconditioning, unaware of safety needs. Goals include, "The resident will be free of falls through the review date. Interventions included, "Anticipate and meet the resident's need. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Follow facility fall protocol. Pt [Physical Therapy] evaluate and treat as ordered or PRN [as	2 830	Corrected.	

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2 830	Continued From page 12 needed]." R137's progress note dated 2/20/2021, at 12:21 p.m. included, "Resident telling CNA [certified nursing assistant] at 1130 that she fell during the night "when it was dark". When this writer approached her states she got up to the bathroom at 0330-0400. Got dizzy and staggered Left then fell to the right. "I passed out". Got up and back to bed not saying anything to anyone. Now c/o [complaining of] back pain mid right side of back. No redness, bruising. VSS [vital signs stable]. Admits having dizzy spells. Encouraged to call for assist with transfers but said "Then I will pee my pants". Also reinforced the need to call right away for staff if falls." R137's medical record lacked documentation of a fall investigation or an interdisciplinary team meeting review of this fall. During an interview on 2/24/21, at 12:53 p.m. the director of nursing (DON) stated she had not been made aware of R137's fall. The DON verified there was not a fall investigation or an interdisciplinary team review of the fall. The DON stated the fall intervention was to encourage R137 to call for assistance per the progress notes. The DON verified she became aware of R137's fall when a surveyor asked for documentation of the fall. The DON stated the licensed practical nurse (LPN)-A did not document on the fall as the fall was not witnessed and LPN-A was unsure if the resident had fallen. During an interview on 02/24/21, at 1:15 p.m. LPN-A stated when there is an unwitnessed fall, the person who finds the resident completes a	2 830		

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2 830	Continued From page 13 fall investigation. LPN-A stated we need to try to determine the root cause of the fall. The provider and family member are contacted, and you make a progress note regarding the incident regarding everything you have done. LPN-A stated R137 told the CNA (certified nursing assistant) she fell between 11:30 a.m. and 12:00 p.m. that she fell during the night. The CNA (certified nursing assistant) reported to LPN-A and she went in there and asked her what happened. LPN-A stated R137 told me she had got up to go to the bathroom, that it was dark, she stood up started to lean and then when she tried to stand up, she fell the opposite way. LPN-A stated she instructed R137 to call for assist and if she did have a fall to let staff know right away. LPN-A stated she did not fill out the fall investigation form. LPN-A stated she did not do one because it happened during the night and she was not sure what had happened, and she was not sure what the protocol was for something like that. LPN-A stated she did not notify the provider or the family about the fall. LPN-A stated the DON was here when this was going on and stated she was also not quite sure how to handle it. LPN-A stated she probably should have filled out the form. LPN-A verified did not follow the facility procedure for falls and stated that this has never happened to her before when somebody stated they had fallen hours earlier. R24 During an observation on 2/22/2021, at 3:04 p.m. R24 laid in bed with his eyes closed and snoring. R24's call light was laced around bed grab bar, bed was in low position, and fall mat was next to the bed. R24's wheelchair was close to the edge of the mat furthest from the bed.	2 830		

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2 830	Continued From page 14 R24's Admission Record, included diagnoses of unsteadiness on feet, lack of coordination, anxiety disorder, altered mental status, cataract, dementia with behavioral disturbance, and abnormalities of gait and mobility. R24's annual Minimum Data Set (MDS) assessment dated 1/6/2021, indicated R24 had severe cognitive impairment and delusions. The MDS identified R24 required extensive assistance from one staff for bed mobility, transfers, and toileting. R24's medical record identified the last fall risk assessment was completed on 11/20/2020. The assessment identified R24 was at high risk for falls. R24's care plan, identified R24 had limited physical mobility related to weakness, dementia, and musculoskeletal impairments. The care plan also included, "is at risk for falls r/t [related to] dementia, inability to transfer self safely, inability to ambulate. Associated interventions included the following; -Education with wife regarding visits (start date 1/3/2020) -Be sure residents call light is within reach, encourage use, and resident needs prompt response to all requests for assistance (start date 2/20/2019) -floor mat at bedside (start date 2/12/2020) -needs meaningful activities that minimize the potential for falls while providing diversion and distraction. Offer to lay down after activities (start date 2/30/2019). -non-skid strips in front of resident recliner on the floor start date 10/2/2019) -Offer toileting upon rising, before bed, before	2 830		

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2 830	Continued From page 15 and after meals and at 10 p.m. Do not leave resident unattended on the toilet (start date 3/17/2020) -Place resident's wheelchair across the room- not close to him when he isn't in the chair (start date 3/17/2020) -Bed in lowest position when R24 is in bed start date (1/3/2020) Facility incident report dated 11/20/2020, at 12:21 p.m. included R24's description of the fall which was documented as "resident states "I wanted you kids to come here and here you are" referring to staff as he was being assisted. The Immediate Action Taken included, "VS [vital signs] obtained and assisted resident to bed, call light within reach, encouraged to use/request for assistance, supervision measures taken throughout the shift, will continue to assess." The remainder of the form that addresses potential causal factors, root cause, and ongoing interventions was blank. R24's corresponding progress note dated 11/20/2020, at 2:56 p.m. included, "resident noted on floor mat at change of shift, writer assessed resident at time. ROM [range of motion] intact VSS [vital signs] and WNL [within normal limits], alert per his baseline, no injury observed at this time, assessed to bed, call light placed with easy reach, resident able to use call light, at this time bed lowered to the floor, [name of physician] and family both notified. R24's record did not include documentation of root cause analysis, fall investigation, or interdisciplinary team meeting of this fall. During an interview on 2/24/2021, at 2:37 p.m.	2 830		

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2 830	Continued From page 16 nursing assistant (NA)-D stated R24 was at risk for falls. NA-D indicated R24 seemed to cycle between good days and bad days. NA-D indicated R24 had days where he was impulsive and would not use his call light and staff had to anticipate his needs. NA-D indicated when R24 had his sleepy days he would make sure to check on him at least every 2 hours. NA-D stated R24's bed needed to be in the lowest position, the floor mat down, call light in place, and his wheelchair near the bed with the breaks locked in case R24 did get up he wouldn't have so far to walk to his chair. During an interview on 2/25/2021, at 4:59 p.m. director of nursing (DON) reviewed R24's record and incident report and confirmed the incident report lacked an investigation into causal factors, determination of root cause, IDT involvement and review/revision of the care plan; DON stated those tasks should have been completed. DON also stated reminding R24 to remember to use his call light was not an appropriate intervention for him because he did not consistently remember to use the call light. Facility policy Fall Risk Assessment dated 12/2007 included, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls. The staff will look for evidence of possible link between the onset of falling (or increase in falling episodes) and recent change sin the current medication regimen. The assessment data shall be used to identify underlying medical conditions that may increase the risk for injury from falls.	2 830		

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2 830	Continued From page 17 The staff with support of the attending physician will evaluate functional and psychological factors that may increase fall risk, The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. PRESSURE ULCER Based on observation, interview, and document review the facility failed to comprehensively assess, monitor, and treat a worsening pressure ulcer for 1 of 3 residents (R138) reviewed for pressure ulcers. Findings include During an observation on 2/24/2021, at 1:36 p.m. R138 laid on his back in bed. Nursing assistant (NA)-F and NA-G assisted R138 with changing incontinent brief. Both NA's indicated they were not aware of any wounds present on R138's bottom. When NA's cleaned R138 and said there were no wounds present, however when R138's buttocks were observed, R138 was observed to have a coccyx wound and a inner left gluteal fold open wound that was approximately the size of a nickel. R138 denied having discomfort or pain related to the impaired skin integrity. Director of nursing (DON) entered the room, confirmed the presences of both wounds and obtained measurements; DON stated coccyx wound was a stage 2- 0.5 cm x 1.0 cm x 0.2 cm in depth, and	2 830		

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2 830	Continued From page 18 the left buttock wound was a superficial stage 2 that measured 2.5 cm in circumference with a depth <0.1 mm. R138's Admission Record, indicated R138 was admitted to the facility on 2/12/2021, with diagnoses that included obesity, diabetes type 2, and schizophrenia. R138's Admit/Readmit Assessment dated 2/12/2021, section labeled Skin Integrity, identified R138 had a pressure ulcer to his sacrum with no further information. Although R138's baseline care plan and/or care plan dated 2/12/2021 identified that R138 had impaired skin integrity related to a surgical wound it did not address the sacral pressure area. R138's activities of daily living care plan dated 2/15/2021, indicated R138 required one staff assist for toileting and transfers, and bed mobility, R138 could reposition himself. R138's bowel and bladder incontinence care plan dated 2/15/2021, included "check resident every two hours and assist with toileting as needed. Provide pericare after each incontinent episode." R138's diabetic care plan directed staff to "Check all of body for breaks in skin and treat promptly as ordered by doctor" and "Monitor/document/report to MD PRN [as needed] for s/sx [sign/symptoms] of infection to any open areas." R138's Weekly Wound Assessment dated 2/18/2021, identified that R138 had a sacrum ulcer however, did not identify the stage of ulcer. The assessment included ulcer measures of 0.2 centimeters (cm) x 0.5 cm, no depth was documented. The assessment did not identify nor	2 830		

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2 830	Continued From page 19 include a specific treatment plan or interventions to treat. R138's progress note dated 2/24/2021, at 2:35 p.m. included, "a special visit with [name of person]. Butt assessment completed. Orders received to clean cleanse with NS [normal saline]. Pat dry. Apply skin prep to periwound. Cover with 2 x 2 [gauze]- cover with tape. Twice per day. Notify provider if drainage present." R138's skin wound note dated 2/24/2021, at 2:46 p.m. included, "Type of Wound: unknown" and "sacral midline- 0.1 x 0.1 x 0.2 cm- unable to visualize the base of wound. No drainage observed from wound. Special visit for NP [nurse practitioner]. Resident denies pain." The note was not authored by the DON who physically measured the wound; the measurements were not consistent with measurements stated by the DON at the time the wound was assessed. Weekly Wound Assessment dated 2/24/2021, at 4:16 p.m. did not include the sacral ulcer assessment and only identified "left buttock pressure 0.2 x 0.5 [cm]." Stage of the left buttock pressure area was not identified on the assessment. During an observation on 2/24/2021, at 6:58 a.m. R138 laid on his back with the head of the bed elevated. During an interview and observation on 2/24/2021, at 8:00 a.m. R138 continued to lay in the same position. Licensed practical nurse (LPN)-A said R138 did not have any pressure ulcers on his bottom.	2 830		

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2 830	Continued From page 20 During an observation on 2/24/2021, at 8:30 a.m. R138 continued to lay in the same position, an unidentified nursing assistant (NA) entered the room and assisted R138 with eating his breakfast. During a subsequent observation at 9:00 a.m. the NA had left the room, and R138 continued to be in the same position. During an interview and observation on 2/24/2021, at 11:55 a.m. R138 laid in bed on his back with the head of the bed elevated. NA-F stated she had just finished feeding him lunch and had not repositioned R138 before or after. NA-F stated R138 wasn't feeling well today, had not done anything with him prior to or after assisting him with lunch, and stated he let us know when he needed something, however oddly today had not put on his light at all so far. During an interview on 2/24/2021, at 1:40 p.m. NA-F stated her and NA-G changed R138 between 6:00 a.m. and 7:00 a.m., he had been wet and had not put on his call light. NA-F stated we (NA-F and NA-G) didn't get him dressed until 11:15-11:30 a.m., because he hadn't been feeling well that morning; NA's stated R138 was wet. NA's both confirmed between the times of 6-7:00 and 11:15-11:30, R138 had not been repositioned and/or offered repositioning because he had not put on his call light. NA-A stated, "I know that's a really long time apart but we try our best." When asked how often R138 was supposed to be repositioned, neither aide could articulate how often R138 should be re-positioned. During an interview on 2/25/2021, at 11:41 a.m. director of nursing (DON) reviewed R138's record, confirmed the admission assessment was not complete, the ulcer had worsened since	2 830		

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2 830	Continued From page 21 measured on 2/18/2021, and lacked a treatment plan. DON confirmed the facility did not have a system in place to determine and individualized turning and repositioning schedule in order to prevent pressure ulcers and/or prevent deterioration of existing ulcers. DON stated the nursing assistance should have repositioned R138 according to the care plan or at least every two hours; If residents refused positioning the expectation was to document the refusal and re-approach. Facility policy Pressure Ulcer Risk Assessment dated 2/2014 included, the purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers. -Assessment: 2. Skin Assessment. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. 3. Monitoring: staff will perform routine skin inspections (with daily care), b) nurses are to be notified to inspect skin if skin changes are identified. 4) because a resident at risk can develop a pressure ulcer within 2-6 hours of onset of pressure, the at risk resident needs to be identified an have interventions implemented promptly to attempt to prevent pressure ulcers. The admission evaluation helps define those initial care plan approaches and interventions. Facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 2/2014 included: The nurse shall describe and document report the following: Full assessment of pressure sore including location, size, stage, length, width, and depth, presence of exudates or necrotic tissue.	2 830		

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2 830	Continued From page 22 Current treatments, including support surfaces. The staff will examine the skin of a new admission for ulcerations or alterations in skin. R23 R23's quarterly Minimum Data Set (MDS) assessment, dated 1/5/21, indicated the resident had moderately impaired cognition and required supervision with eating. The MDS further identified a diagnosis of end stage renal disease (ESRD), and received dialysis services. R23's care plan, included a potential nutritional problem related to diet restriction for end stage renal disease and diabetes. Interventions included a 1500 cc (cubic centimeter) fluid restriction. R23's active physician orders, included: Fluid restriction - 1200 cc's per day, with an order date of 1/19/21. Review of R23's Medication Administration Record (MAR), and Treatment Administration Record (TAR) printed 2/25/21, and dated 2/1/21 - 2/28/21, did not include evidence of fluid monitoring by nursing staff. R23's Dietary Card, printed 2/25/21, indicated: Fluid Restriction, 240 cc per meal. The undated form titled, Water Pass, provided by the dietary manager (DM), indicated R1 was on a 120 cc fluid restriction with each water pass. On 2/22/21, at 3:39 p.m. R23 confirmed being on a 1200 cc fluid restriction and stated, "But they bring me water whenever I ask for it". R23 was	2 830		

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2 830	Continued From page 23 not sure if staff were tracking her fluid intake and shared one night had asked for water and the overnight staff gave her a large mug, "I told staff I didn't think I was supposed to have all that." On 2/24/21, at 12:14 p.m. R23 was observed in her room eating lunch. The meal included juice in an 8 ounce cup (240 cc) with a cover and straw. There were no other fluids included with the meal. On 2/25/21, at 1:22 p.m. activities aide (AA)-B confirmed activity staff could provide beverages at times for residents. AA-B stated there was only one resident she knew of that was on a fluid restriction; the resident was not DIALYSIS Based on observation, interview and document review the facility failed to implement adequate systems for monitoring fluid intake for 2 of 2 residents (R13 and R23). In addition, the facility failed to ensure the dialysis access site was monitored and assessed upon return to dialysis treatment, and failed to notify the dialysis center when the dialysis site was bleeding for 1 of 2 residents (R13) reviewed for dialysis. Findings include: R13's Admission Record, included diagnosis of end stage renal disease, dependence on renal dialysis, and essential hypertension. R13's annual Minimum Data Set (MDS) assessment dated 12/6/2020, did not identify R13's cognition. The MDS indicated R13 required staff assistance for activities of daily living and required dialysis.	2 830		

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2 830	Continued From page 24 R13's nutritional care plan dated 12/1/2021, included record and monitor intake daily, and weigh resident per facility protocol and monitor weights. The hydration care plan dated 1/7/2020, identified R13 was at risk for dehydration or potential fluid deficit related to regular loose stools; associated interventions included, educate resident/family on importance of fluid intake, offer drinks during one to one visits, ensure all beverages offered comply with diet/fluid restrictions and consistency requirements, monitor for signs of dehydration, and monitor and document intake and output as per facility policy. R13's care plan for hemodialysis dated 9/13/2019, directed the following: Check and change dressing daily at access site. Document. Check patency of the site as ordered, palpate the site to feel the thrill or use stethoscope to hear the whoosh or bruit of blood flow through the access, R13 received dialysis on Monday, Wednesday, and Fridays. If there is a major bleeding form site (post dialysis), apply pressure to insertion site and contact emergency services and dialysis center. This is a medical emergency. Do not leave resident alone until emergency services arrive. Monitor/document/report as needed for signs/symptoms of bleeding, hemorrhage, bacteremia, septic shock. Resident has an AV fistula on right upper arm, resident is on a 1.5 liter fluid restriction, and resident receives hemodialysis [name of dialysis clinic]. R13's physician orders included -Arginaid (nutritional supplement) 8 ounces (oz.) twice per day (start date 9/11/2019). -Please remove fistula bandages after 4 hours after each "Hb" (sic), if bleeding occurs, apply ten	2 830		

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2 830	Continued From page 25 minutes pressure, then recheck. If bleeding still occurs, send patient to the ER every evening shift on Monday, Wednesday, Friday (start date 3/13/2020) -Check for presence of bruit/thrill- right arm every shift notify physician if absent (start date 2/28/2020) -Document dry weights when returning from dialysis obtain weight from dialysis (start date 2/12/2021) -Ensure resident has dialysis bag with dialysis supplies (start date 9/10/2020) -Fluid restriction 1500 ml (milliliters) per day. -Furosemide 40 mg (milligrams) two times a day (start date 8/29/2019). During an interview on 2/22/2021, at 6:37 p.m. R13 sat up in his wheelchair in his room. R13 stated he received dialysis on Monday, Wednesday, and Friday. R13 pointed to his right arm where his dialysis port was located; was a raised area on his shirt from underlying bandage (no bleeding observed through shirt). R13 stated staff had not checked the bandage for bleeding when he arrived back at the facility, and stated staff did not always check after the appointment. R13's progress note dated 1/5/2021 (Tuesday), at 1:39 p.m. included "When dressing removed from R [right] arm area this morning small amount of bright blood oozing from fistula. No blood on soiled dressing. Another dressing applied and when now removed no ne [sic] on dressing and is no longer bleeding. R13 record did not identify approximate amount of blood loss, how long the site was bleeding, how long pressure was applied, and lacked evidence of communication to the dialysis clinic.	2 830		

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2 830	Continued From page 26 R13's progress note dated 1/6/2021, at 10:45 a.m. included, "No bleeding form fistula R arm prior to leaving for dialysis. No signs of bleeding after dressing removed yesterday." On 2/25/2021, at 8:29 a.m. surveyor contacted R13's dialysis clinic and obtained records from 1/6/2021. R13's dialysis note dated 1/6/2021, included "Patient reported fistula bleeding at nursing home. Patient stated it started yesterday after the staff took the gauze dressing off and that it bled a large amount and needed manual pressure held for a "long time". Unable to say how long. Gauze wrap was replaced and taken off this AM and patient reported it was still leaking some at this time. R13's dialysis communication notebook was reviewed from 1/4/2021 to 1/6/2021, no entries were made pertaining to R13's dialysis site bleeding. During an interview on 2/25/2021, at 9:06 a.m. licensed practical nurse (LPN)-A stated she was the nurse working when R13's dialysis site was bleeding and wrote the progress note. LPN-A stated that morning she went in to check for bruit and thrill, there had not been a bandage on, and the site was dripping blood. LPN-A stated she applied a gauze pressure dressing to stop the bleeding, and when she came back there was only a small amount of blood on the dressing and the bleeding had stopped. LPN-A stated she thought she had rechecked the site after 30 minutes. LPN-A stated she had not notified dialysis of the bleeding because it was not a large amount and the bleeding stopped. During an interview on 2/25/2021, at 8:29 a.m.	2 830		

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2 830	Continued From page 27 dialysis registered nurse (DRN) stated she was R13's care manager. DRN reviewed R13's visit notes dated 1/6/2021, and stated at the beginning of treatment patients are asked if they had any post bleeding issues; R13 was capable of telling us and was a reliable historian and knowledgeable when it came to his dialysis. DRN read the visit note aloud from 1/6/2021, and stated the facility had not communicated R13's site had post bleeding. DRN stated it would depend on the amount of bleeding if it was considered an emergency. DRN stated staff were supposed to apply pressure if they noted bleeding; stated the facility should have notified us of any bleeding either via phone or by writing it down it the communication book that goes back and forth. R13's January and February 2021 medication administration record (MAR) identified the physician orders for the Arginaid; recorded fluid intake values ranged from 60 ml to 240 ml. R13's January and February 2021 treatment administration record (TAR) identified physician orders to check the fistula; the boxes had a check marked boxes indicating the task was completed on every dialysis day. The TARs also included the physician order for 1500 ml fluid restriction, however all of the boxes had an "X", with no fluid intake amount recorded. R13's record identified fluid intake was being recorded in two areas, "Meal intake" and "fluid intake". The recorded values were not consistent with each other, and the record lacked evidence of evaluation/assessment of R13's twenty-four hour intake. Examples include -Fluid intake documentation for 2/20/2021- the	2 830		

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2 830	Continued From page 28 three boxes were blank; corresponding Meal intake for 2/20/21, indicated R13 consumed 240 ml for breakfast, lunch box was left blank, R13 consumed 240 ml for dinner. The MAR Arginaid consumption; R13 consumed 120 ml in the morning and evening. -Fluid intake documentation for 2/21/2021- two boxes were left blank and 3rd box had 240 ml recorded; corresponding Meal intake for 2/21/2021, had blank box for breakfast intake, lunch intake was 240 ml, and dinner intake was 120 ml. The MAR arginaid consumption was 120 ml in the morning and evening. -Fluid intake documentation for 2/22/2021, two boxes were left blank and two boxes had "0"; corresponding Meal intake for 2/22/2021, had 240 ml for breakfast, a blank box for lunch, and 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. -Fluid intake documentation for 2/23/2021, two boxes had "0" recorded and one box was blank; corresponding Meal intake for 2/23/2021, had blank box for breakfast, 240 ml for lunch, and 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. During an interview on 2/24/2021, at 2:31 p.m. registered nurse (RN)-B stated nurses are documenting fluid intake on the TAR's. RN-B reviewed the areas in R13's record where fluid intake was documented and stated it could not be determined how much fluid intake R13 consumed on a daily basis. RN-B stated the dietician would be a good person to evaluate daily fluid totals. During an interview on 2/24/2021, at 2:38 p.m.	2 830		

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2 830	Continued From page 29 NA-D stated dietary staff recorded fluid intake in the computer after they picked up meal trays. During an interview on 2/24/2021, at 2:39 p.m. NA-J stated she used to work in dietary. NA-J stated dietary staff would record the amount of intake in the computer for each meal, if dietary staff did not have time on their shift, the next shift would record it for them. NA-J stated they did not record any other intake besides what the resident was provided with meals. NA-J indicated an unawareness of who was documenting the amount of fluid intake outside of meals. During an interview on 2/25/2021, at 8:15 a.m. nursing assistant (NA)-I stated she was not sure if R13 was on a fluid restriction or not. NA-I stated NA's did not record fluid intake and that kitchen people tracked that. During an interview on 2/26/2021, at 8:51 a.m. trained medication assistant (TMA)-A stated when she passed medications she did not record the amount of fluid intake and dietary staff tracked fluid intake. During an interview on 2/26/2021, 9:18 a.m. RN-A stated if a resident was on a fluid restriction, the dietician determined how much fluid was divided over each meal, how much the resident could have in his room, and the amount allowed for medication passes. RN-A stated NA's were supposed to communicate to the nurse if the resident was requesting additional fluids outside of what they were provided. RN-A stated "I don't believe that there is someone evaluating the 24 hour totals, our dietician may go in but I can't confirm that."	2 830		

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2 830	Continued From page 30 During an interview on 2/25/2021, at 11:22 a.m. director of nursing (DON) confirmed the record did not identify dialysis or provider was contacted when R13's dialysis site was bleeding, and they should have been and/or should have been in the dialysis communication book. DON indicated there should have been documentation of how/when the site was monitored for bleeding and expected staff check the site after dialysis according to physician orders. DON reviewed R13's fluid intakes and stated the facility did not have a solid way fluid intakes were being documented and evaluation of the intakes was not being completed. During an interview on 2/26/2021, at 9:39 a.m. certified dietary manager (CDM) stated dietary and housekeeping staff pass water twice per day, if a resident is on fluid restriction it is identified on a sheet of paper. CDM stated dietary staff are supposed to record fluid intake after each meal in the computer. CDM stated an unawareness of who was evaluating 24-hour daily fluid intakes. CDM stated an unawareness who was documenting fluid intake provided outside of meals such as fluids given during activities, during medication passes, or extra amounts the resident requests. R23. On 2/25/21, at 1:26 p.m., trained medication aide (TMA)-B stated to her knowledge, R23 was not on a fluid restriction. TMA-B confirmed when a resident was on a fluid restriction, nursing would monitor fluid intake with medications and dietary would monitor fluids consumed with meals and water pass. On 2/25/21, at 1:31 p.m. nursing assistant	2 830		

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2 830	Continued From page 31 (NA)-H stated being unaware if R23 was on a fluid restriction as didn't work the east wing very much where R23 resided. On 2/25/21, at 1:35 p.m. licensed practical nurse (LPN)-A stated to her knowledge, R23 was not on a fluid restriction. LPN-A further stated typically the dietary staff delegated and monitored what fluids were received by residents on a fluid restriction, and nursing would monitor fluids they administered on the MAR or TAR. LPN-A reviewed R23's physician orders and confirmed R23 was on a 1200 cc daily fluid restriction. When asked where nursing would document R23's fluid intake, LPN-A responded, "Good question". LPN-A reviewed R23's MAR and TAR and confirmed there was no tracking of fluid intake by nursing. On 2/25/21, at 1:43 pm. the dietary manager (DM) confirmed dietary staff were responsible for passing out water to residents and also for documenting how much water was consumed for residents on a fluid restriction. The staff that does the water pass has a sheet that indicated who was on a fluid restriction and how much they could receive. Dietary staff also tracked how much fluid was consumed at meals, and thought it was around 240 cc's at each meal, though if the resident requested more fluids than that staff couldn't refuse the resident's request. DM confirmed the dietician, who came to the facility weekly, was responsible for tracking fluid intake for resident's on a fluid restriction and would educate the resident if consuming more than prescribed. DM confirmed R23 was on a fluid restriction, and further confirmed the restriction was recently reduced from 1500 cc to 1200 cc daily. DM was unsure how nursing staff were	2 830		

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2 830	Continued From page 32 notified when a resident was on a fluid restriction. When interviewed on 2/25/21, at 3:36 p.m. the director of nursing (DON) confirmed staff should have been monitoring R23's fluid intake and that dietary staff's monitoring was not complete. DON further confirmed nursing should have been aware of R23's fluid restriction. When interviewed on 2/26/21, at 9:40 a.m. the DM confirmed dietary staff should be charting how much fluid was consumed for each meal and water pass. DM reviewed R23's fluid intake with meals and confirmed staff had not been consistently documenting how much fluid was consumed at each meal. A copy of R23's fluid intakes from 1/19/21 to 2/26/21 was requested but not received. Facility policy Hemodialysis Access Care dated 10/2010, included: Mild bleeding from the site (post dialysis) can be expected. Apply pressure to insertion site and contact dialysis center for instructions. If there is major bleeding from the site (post dialysis), apply pressure to insertion site and contact emergency services and dialysis center. Verify that clamps are closed on lumens. This is a medical emergency. Do not leave resident alone until emergency services arrive. SKIN INTEGRITY AND FLUID MONITORING Based on observation, interview, and document review the facility failed to identify, complete a comprehensive skin assessment of impaired skin integrity of a foot ulcers upon admission for 1 of 2 residents (R139) reviewed for impaired skin integrity. In addition, the facility failed to monitor	2 830		

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2 830	Continued From page 33 and evaluate fluid intake for a physician prescribed fluid restriction and failed to consistently monitor and evaluate edema for 1 of 1 residents reviewed (R2) who had a diagnosis of congestive heart failure and had a history of hospitalization related to fluid overload. Finding include: During an observation and interview on 2/22/2021, at 3:30 p.m. R139 sat on his bed. R139 stated he was admitted to the facility a few days ago because of a gangrene infection in his groin that needed dressing changes that he could not see to do himself. When asked if he had any other sores or pressure ulcers, R139 said he had an open sore on the bottom of right foot the size of a dime that used to be a big blister. R139 stated there was a dressing over the wound now that had been on since he had been admitted to the hospital and has not been changed. R139 added he also had some areas on two of his toes of the left foot that he thought were healing. R139 was asked if staff had seen the wounds to his feet, in response R139 said noone here had looked at the wounds and had not asked about any other skin conditions. R139's Admission Record, indicated R139 had been admitted to the facility on 2/20/2021, with diagnoses of diabetes type 2, Fournier gangrene, chronic obstructive pulmonary disease, and morbid obesity. R139's hospital discharge summary dated 2/19/2021, indicated R139 had been admitted to the hospital on 2/8/2021 and discharged on 2/19/2021. The summary also included diagnoses of diabetic peripheral neuropathy and	2 830		

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2 830	Continued From page 34 congestive heart failure that was not included on the facility's list of diagnoses. The discharge summary identified the groin wound and the treatment of, however did not identify that R139 had ulcerations to his feet. R139's Admit/Readmit Assessment dated 2/20/21, in section titled Skin Integrity, did not identify the impaired skin integrity to R139's feet. During an observation and interview on 2/23/2021, at 8:52 a.m. R139 laid in bed, registered nurse (RN)-A and director of nursing (DON) were present in the room to change the dressing to R139's groin. At the completion of the dressing change both RN-A and DON were going to leave the room, surveyor requested RN-A to look at R139's feet. RN-A took off R139's right sock exposing a gauze bandage wrapped around the top of his foot. RN-A donned gloves, removed the dressing that exposed the ulceration on the bottom of R139's foot. RN-A measured the wound; stated it was 1.0 centimeters (cm) x 2.0 cm x 0.1 cm in depth. RN-A then removed R139's left sock, there was an area on the big toe with no dressings were present. RN-A measured the wound on the great toe; 2.9 cm x 1 cm with of depth of 0.2 cm. R139's lower extremities were observed to be very dry with thick scaley skin. R139 stated he had been putting vaseline on them at home. R139's corresponding progress note dated 2/23/2021, at 9:35 a.m. included "Contact [name of wound clinic]- updated on dry feet, left great toe, and right plantar foot. Initial wound assessments completed. Orders recieved for hydrofera blue and cover q [every] 3 days to right plantar. Keep left great toe clean and dry.	2 830		

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2 830	Continued From page 35 Change dressing q 3 days. Vaseline to feet." During an interview on 2/23/2021, at 3:55 p.m. licensed practical nurse (LPN)-B stated he had worked on 2/20/2021, had changed the dressing to R139's groin however did not know anything about the impaired skin integrity to R139's feet. During an interview on 2/23/2021, at 3:59 p.m. nursing assistant (NA)-E stated she had provided cares to R139 the last couple of days and had worked on 2/20/21 when R139 was admitted. NA-E stated she was only aware that R139 had a wound in his groin and nowhere else. NA-E stated on 2/20/21, she had asked what R139 needed help with and he wanted his socks left on so she had not seen his feet. NA-E stated she did not ask R139 if she could inspect his feet for impaired skin integrity and did not ask if he had any sores. During an interview on 2/23/2021, at 4:47 p.m. RN-A stated she had not previously been aware of the wounds on R139's feet before today. During an interview on 2/23/2021, at 5:06 p.m. DON stated she had completed R139's admission, however reported to the evening shift nurse she had not completed the entire body audit and asked that the nurse complete it. DON stated she did not follow-up with the nurse and had assumed that it had been completed. DON stated she had not been previously aware of the wounds to R139's feet. DON stated it was expected that a full body audit be completed upon admission, and indicated staff should be looking at or asking independent residents to complete body audits.	2 830		

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2 830	Continued From page 36 R2 During an observation on 2/26/21, at 8:42 a.m. R2 sat in his wheelchair in his room with his legs down in the dependent position. R2 had tubi grips on to both legs, both legs observed to be edematous with the right worse than the left. R2 stated he was on a 1.5 liter fluid restriction, and thought he had been following. R2 stated that the facility passed water and their was water in the sink. R2 stated he elevated his legs at night to help with the swelling, and were up in the air from 7:00 p.m. to 6:00 a.m. R2 stated staff weighed him before breakfast and staff checked for edema but not daily. R2's Admission Record, included diagnoses of hypertensive heart and chronic kidney disease with heart failure, and shortness of breath. R2's scheduled (PPS) Minimum Data Set assessment dated 1/13/2021, identified R2 did not have cognitve impairment and indicated R2 was not administered diuretic medications. R2's physician orders included: -Daily weight for edema (Start date 12/5/2020) -Fluid restriction 2000 milliliters (ml) per day (start date 1/28/2021) - Tubi grips- on in the morning off at bedtime for edema (start date 12/17/2020) -Metolazone (diuretic) 2.5 milligrams (mg) every Monday, Wednesday, Friday for fluid restriction (start date 2/15/2021) -Tousemide (diuretic) 40 mg twice per day for congestive heart failure (start date 1/28/2021) R2's nutritional care plan, included: follow fluid	2 830		

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2 830	Continued From page 37 restriction 2 liters per day, record and monitor intake daily, weigh resident per facility protocol. R2's care plan identified R2 had diagnoses of hypertension and congestive heart failure; associated interventions included monitor for and document any edema notify physician, weight weekly, monitor/document/report as needed any signs/symptoms of congestive heart failure. EDEMA R2's record was reviewed from 2/10/21 to 2/22/21, R2's record did not include consistent edema monitoring and evaluation according to the care plan and physician orders. R2's progress note dated 2/11/2021, at 2:20 p.m. indicated R2 had a hard cast removed and cam boot applied to his right foot, and weight variance may be related to the new device. Breath sounds even and unlabored lung sounds clear. Bilateral lower edema 1+. Tubigrips on both lower extremities and left arm. A subsequent note at 9:17 p.m. indicated at 6:00 p.m. R2 had showed nurse several fluid filled blister and open wounds on the right leg were the cast was. R2's progress note dated 2/20/21, included "... +3 pitting edema to lower legs and feet bilaterally. Left arm edema present from elbow to fingers. R2's progress note dated 2/21/21, at 2:01 a.m. included "resident coughing 0100 [sic] blood. Listening to lungs wheezing could be heard in his right upper lungs." A subsequent note at 5:50 a.m. included, "Resident die [sic] not cough out anymore bloody phlegm, vitals stable will continue to monitor resident for change of condition and update primary provider.	2 830		

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2 830	Continued From page 38 R2's weight change note dated 2/21/21, indicated R2 triggered for weight gains... R2's progress note dated 2/21/21, at 8:00 p.m. included "lungs has a bit of wheezing in the left upper side." Daily weights identified fluctuations in R2's weights and indicated R2 was not weighed at the same time every day. 2/11/21, at 11:32 a.m. - 262 pounds lbs. 2/12/21, at 10:21 a.m. - 265.2 2/13/21, at 1:42 a.m. -264.4 2/14/21, at 9:54 a.m.-265.2 2/15/21, at 2:02 p.m. -264.2 2/16/21, at 12:52 p.m. -265.4 2/17/21, at 11:14 a.m.-261.8 2/18/21, at 10:55 a.m.-266.0 2/19/21, at 12:49 p.m.-269.2 2/20/21, at 12:49 p.m.-266.4 2/21/21, at 1:07 p.m. -266.8 2/22/21, at 9:55 a.m. -265.4 FLUID INTAKE R2's record lacked evidence of monitoring and evaluation of fluid intake according to physician orders and the care plan. R2's Fluid Intake record was reviewed from 2/10 to 2/22/21, the record lacked consistent recording of fluid intake, and the record lacked evidence of evaluation of 24 hour fluid intake in order to identify fluid volume deficits and/or overages. Based on the documentation it cannot be determined if R2's 2 Liter fluid restriction was followed according to physician orders. On 2/10/21, breakfast intake documented as "not applicable", for lunch and dinner intake was 240	2 830		

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2 830	Continued From page 39 ml. On 2/11/21, breakfast intake documented as "0", lunch 200 ml, and dinner 200 ml, dinner documented as "not applicable" On 2/12/21, breakfast was 225 ml, lunch 200 ml, dinner- was left blank On 2/13/21, breakfast was documented as "not applicable" lunch 240 ml, dinner 240 ml On 2/14/21, breakfast was 240 ml, lunch 240 ml, dinner documented as "not applicable" On 2/15/21, breakfast was 120 ml, lunch 120 ml, dinner was left blank. On 2/16/21, no fluid intake was recorded for the day On 2/17/21, breakfast 240 ml, lunch 240 ml, dinner was left blank. On 2/18/21, 240 ml was recorded for each meal. On 2/19/21, breakfast was left blank, lunch 240 ml, dinner was left blank On 2/20/21, breakfast was left blank, both lunch and dinner intake was 240 ml On 2/21/21, breakfast was left blank, lunch 120 ml, dinner 180 ml. During an interview on 2/24/2021, at 2:31 p.m. registered nurse (RN)-B stated nurses are documenting fluid intake on the TAR's [treatment administration record]. RN-B reviewed the areas in R2's record where fluid intake was documented and stated it could not be determined how much fluid intake R2 consumed on a daily basis. RN-B stated the dietician would be a good person to evaluate daily fluid totals. During an interview on 2/24/2021, at 2:38 p.m. NA-D stated dietary staff recorded fluid intake in the computer after they picked up meal trays. During an interview on 2/24/2021, at 2:39 p.m.	2 830		

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2 830	Continued From page 40 NA-J stated she used to work in dietary. NA-J stated dietary staff would record the amount of intake in the computer for each meal, if dietary staff did not have time on their shift, the next shift would record it for them. NA-J stated they did not record any other intake besides what the resident was provided with meals. NA-J indicated an unawareness of who was documenting the amount of fluid intake outside of meals. During an interview on 2/25/2021, at 8:15 a.m. nursing assistant (NA)-I stated she was not sure if R2 was on a fluid restriction or not. NA-I stated NA's did not record fluid intake and that kitchen people tracked that. During an interview on 2/26/2021, at 8:51 a.m. trained medication assistant (TMA)-A stated when she passed medications she did not record the amount of fluid intake and dietary staff tracked fluid intake. During an interview on 2/26/2021, 9:18 a.m. RN-A stated if a resident was on a fluid restriction, the dietician determined how much fluid was divided over each meal, how much the resident could have in his room, and the amount allowed for medication passes. RN-A stated NA's were supposed to communicate to the nurse if the resident was requesting additional fluids outside of what they were provided. RN-A stated "I don't believe that there is someone evaluating the 24 hour totals, our dietician may go in but I can't confirm that." During an interview on 2/25/2021, at 11:22 a.m. director of nursing (DON) reviewed R2's fluid intakes and stated the facility did not have a solid way fluid intakes were being documented and	2 830		

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2 830	Continued From page 41 evaluation of the intakes was not being completed. During an interview on 2/26/2021, at 9:39 a.m. certified dietary manager (CDM) stated dietary and housekeeping staff pass water twice per day, if a resident is on fluid restriction it is identified on a sheet of paper. CDM stated dietary staff are supposed to record fluid intake after each meal in the computer. CDM stated an unawareness of who was evaluating 24-hour daily fluid intakes. CDM stated an unawareness who was documenting fluid intake provided outside of meals such as fluids given during activities, during medication passes, or extra amounts the resident requests. Facility policy Pressure Ulcers/Skin Breakdown-Clinical Protocal dated 2/2014 included 2. The nurse shall descrbe and docuemtn reprot the following: Full assessment of pressure sore including location, size, stage, length, width, and depth, presence of exudates or necrotic tissue. Current treatments, including support surfaces. 3. The staff will examine the skin of a new admission for ulcerations or alterations in skin. Facility policies for management of congestive heart failure/fluid intake monitoring/edema managemet were requested and were not provided. SUGGESTED METHOD OF CORRECTION: FALLS: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented and the	2 830		

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2 830	Continued From page 42 provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. PRESSURE ULCERS: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. DIALYSIS: DON/designee could review/revise facility policies/procedures, and provide re-education to nursing staff for coordination of care with the dialysis clinic. In addition, the facility could develop and implement a system for recording/monitoring/and evaluation fluid intake. The facility could then develop and implement an auditing system as part of the quality assurance activities to maintain compliance. FLUID MANAGEMENT: DON/designee could develop policies/guidelines monitoring and evaluating fluid balance. The DON/designee could then provide education to nursing staff, and develop an auditing system as part of the quality assurance activities to ensure ongoing compliance. IMPAIRED SKIN INTEGRITY: DON/designee could review polices/protocols for admission skin	2 830		

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2 830	Continued From page 43 assessment. DON/designee could then re-educate nursing staff. The facility could then implement an auditing system as part of their quality assurance activities to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 by ensuring staff utilized appropriate personal protective equipment (PPE) precautions, including the use of gowns, when providing direct care to residents newly admitted/re-admitted to the facility during their 14-day quarantine for 3 of 3 residents (R 138, R139, R137) observed. in addition, the facility failed to ensure new admission presumed positive residents were quarantined in their room for 14-days for 1 of 1 residents (R139) who attended the group resident council meeting. The facility also failed to ensure proper infection control technique while administering medication for 1 of 7 residents (R11) observed during medication administration.	21375	Corrected.	4/14/21

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21375	Continued From page 44 Findings include: R138's face sheet, identified an admission date to facility on 2/12/2021, with diagnoses that included obstructive sleep apnea and ventral hernia with gangrene. R138's hospital discharge summary, indicated during R138's hospital course he developed and treatment was started for ventilator associated pneumonia. The summary indicated upon discharge from the hospital R138 was "noted to have expiratory wheezes to auscultation.", chest X-ray showed persistent bilateral airspace opacities with some progression in the left lower lobe, possible pneumonia. During an observation on 2/22/2021, at 3:07 p.m. R138's room did not have signage or personal protective equipment (PPE) outside of his room that would identify R138's required transmission based precautions. R138 was observed to be sitting in his recliner in his room. During an observation on 2/22/2021, at 4:10 p.m. R138 sat in his recliner in his room. R138 stated he was going to call 911 for his cough. R138 coughed (dry non-productive, covered his mouth). Nursing assistant (NA)-E stood next to R138; NA-E wore a face mask and eyes shield but did not have a gown on. NA-E attempted to redirect R138 from calling 911. NA-E washed and sanitized her hands before she exited R138's room. During an observation and interview on 2/22/2021, at 4:15 p.m. registered nurse (RN)-A entered R138's room with a face shield and a mask on; RN-A did not have a gown on. RN-A	21375		

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21375	Continued From page 45 indicated R138 had been admitted from the hospital and had been treated in the hospital for respiratory illness not related to COVID-19 and had a dry cough intermittently since admission. RN-A indicated R138 was quarantined related to new hospital admission, confirmed there was not signage or PPE outside of R138's room. R139 R139's face sheet, identified an admission date to facility of 2/20/21 with diagnoses including diabetes and chronic obstructive pulmonary disease. R139's hospital discharge summary dated 2/19/2021, indicated R139's tested negative for Covid-19 on 2/19/2021. The summary did not include why R139 was tested for COVID-19. During an observation and interview on 2/22/2021, at 3:30 p.m. R139's room did not have signage or PPE outside of his room. R139 sat in his bed. R139 stated he had just been admitted to the facility a couple of days ago; facility staff had informed him he was supposed to be quarantined for a while and had been only been out of his room to get weighed. R139 was not observed to have respiratory symptoms. During an observation on 2/23/2021, at 8:52 a.m. RN-A and director of nursing (DON) were in R139's room; both wore a face mask and face shield however did not have a gown on. RN-A changed R139's groin dressing. R139 was not observed to have respiratory symptoms. R137 R137's face sheet, identified an admission date	21375		

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21375	Continued From page 46 to facility of 2/12/21 with diagnoses including altered mental state and avoidant personality disorder. During an observation and interview on 2/22/2021, at 4:27 p.m. R137's room did not have signage or PPE outside of her room. R137 stated she had been admitted to the facility almost two weeks ago. R137 was not observed to have respiratory symptoms. During an interview on 2/23/2021, at 4:06 p.m. NA-H indicated that the one hallway was where the facility put residents who came from the hospital and those residents were on quarantine, (R137, R138, and R139). NA-H stated we have not ever been required to wear gowns for hospital admissions, only masks and face shields. NA-H confirmed that there was no signage or PPE stations down that hallway or in front of the residents rooms, and if you were not an employee of the facility you would have to ask the nurse to find out if there were any special precautions. NA-H stated R137 and R139 have not had any symptoms, and R138 had been admitted with a dry cough that would come and go; stated it was something else besides COVID-19. During an interview on 2/23/2021, at 4:11 p.m. licensed practical nurse (LPN)-B confirmed that there was not PPE stations or signage in front of the resident's rooms that were on quarantine related to hospital admissions. LPN- indicated if there was a cause of concern, then gowns should be worn. When interviewed on 2/23/21, at 3:15 p.m. the director of nursing (DON) confirmed all residents	21375		

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21375	Continued From page 47	21375		

that are admitted or re-admitted from the hospital into the facility need a negative Covid-19 test and are quarantined to their room for 14 days. DON stated at the last facility she worked at the staff utilizing full PPE when entering the room of a resident on quarantine and confirmed at this facility staff had not been utilizing gowns when entering quarantined resident rooms. DON was unsure how many gowns were on hand at the facility.

When interviewed on 2/23/21, at 4:36 p.m. DON confirmed the facility had 8 cases of gowns in storage and would be initiating droplet precautions including the use of gowns immediately for the new and re-admitted residents.

The policy titled COVID-19, revised 6/1/20, indicated: Persons Under Investigation (PUI)/ suspected covid in the facility. As a precautionary measure, any suspected cases will be handled as follows: Use standard precautions, contact precautions, and eye protection, and a mask...Precaution signs will be placed on the door.

R11 medication administration

R11's Admission Record (face sheet), indicated R11 had diagnoses including unspecified convulsions and anxiety disorder.

R11's Order Summary Report (physician's orders) signed 2/25/21, included orders for Tegretol (carbamazepine) (an anticonvulsant medication used to treat seizure disorders) 200 milligrams (mg) give 1 tablet by mouth three times a day, fish oil 1000 mg give one capsule by

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 48 mouth two times a day, gabapentin (an anticonvulsant medication also used to treat nerve pain) 100 mg give 2 capsules by mouth two times a day, magnesium oxide give 400 mg by mouth in the morning, multiple vitamin give one tablet by mouth in the morning, and paroxetine HCl (an antidepressant medication) 20 mg give 40 mg by mouth in the morning. On 2/24/21, at 8:03 a.m. trained medication aide (TMA)-B was observed setting up medications for R11 in the following order: gabapentin 100 mg-2 tablets, Tegretol 200 mg, fish oil 1000 mg, magnesium oxide 400 mg, and multiple vitamin-1 tablet. After dishing up the multiple vitamin, TMA-A obtained a medication in a blister package (a packing design consisting of pre-formed plastic attached to a backing or that folds together to form a seal). TMA-B pushed one of the tablets out of the blister package, then handed the package to the surveyor to review. The medication was Tegretol 200 mg give one tablet by mouth three times a day and had a blue sticker on it that read, "Bedtime". Surveyor brought to TMA-B's attention that she had already dished up R11's morning Tegretol dose and that this was the bedtime dose. TMA-B removed the Tegretol tablet from the medication cup with her bare hands, then replaced the medication back into the blister package. TMA-A then obtained a different medication blister package and pushed one of the tablets out of the blister package into the medication cup, then handed the package to the surveyor to review. The medication was Tegretol 200 mg by mouth three times a day. Again, surveyor pointed out to TMA-B that she had already dished up that medication. TMA-B again removed the extra dose of Tegretol from the med cup with her bare	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00073	A. BUILDING: _____ B. WING _____	C 02/26/2021

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CALEDONIA REHABILITATION & RETIREMENT	425 NORTH BADGER STREET CALEDONIA, MN 55921

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21375	Continued From page 49 hands, then replaced the medication back into the blister package. When interviewed on 2/24/21, at 8:19 a.m. TMA-B confirmed it was the facilities practice to tape medications back into the blister pack if punched out by mistake. TMA-B further confirmed it was ok to use her bare hands to remove the medications from the med cup as she utilized the hand sanitizer so much that it's ok. When interviewed on 2/24/21, at 1:20 p.m. the director of nursing (DON) stated she would expect the TMA or nurse doing medication administration to discard a medication if it was popped out of a blister package in error, and not place it back into the blister package with tape on the back. DON further confirmed staff should not be touching medications with their bare hands as this was an infection control concern. The policy titled, Administering Medications, revised 11/28/20, indicated: Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications. RESIDENT COUNCIL MEETING R139's face sheet, identified an admission date to facility of 2/20/21 with diagnoses including diabetes and chronic obstructive pulmonary disease. R139 attended the facility resident council meeting held during the survey on 2/23/21, at 10:00 a.m. R139 was a new admission to the facility and should have been on 14 day presumed positive quarantine.	21375		

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21375	Continued From page 50 During an interview on 2/25/21, at 9:12 a.m. the director of nursing (DON) stated the ombudsman gave her the names of the residents who attended the resident council meeting and she immediately said R139 should not have attended as he was a new admission and was presumed positive and was on quarantine. The DON stated every new admission to the facility was on presumed positive 14-day quarantine and stated the 400 hall was the facility quarantine hall. The DON stated the activity director (AD) was aware R139 was on a quarantine hall and stated in her defense we did not have anything posted to indicate the residents on the 400 hall were in quarantine. The DON stated presumed positive residents were to stay in their rooms for 14 days. During an interview on 2/25/21, at 11:39 a.m. the AD stated there was a misunderstanding between her and admission coordinator (AC). The AD stated she asked the AC if R139 could participate in the resident council meeting because he was on quarantine and AC stated it was fine as she thought interviews would be completed in individual rooms. The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including personal protective equipment required and quarantine practices for hospital returns and new admission who are presumed positive upon admission to the facility, and could verify staff training and implementation of CDC and CMS guidelines are implemented to reduce risks for COVID-19. Then the DON or designee could conduct routine audits to ensure the policies are being followed.	21375		

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21375	Continued From page 51 Time Period for Correction: One (1) day.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a facility risk assessment for tuberculosis (TB) was conducted per current Center for Disease Control and Prevention (CDC) recommendations. This had the potential to affect all residents residing in the facility. Findings include:	21426	Corrected.	4/14/21

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21426	Continued From page 52 When interview on 2/26/21, at approximately 3:25 p.m. the director of nursing confirmed the facility had no evidence a current TB facility risk assessment had been completed. Policies related to TB were requested but not received. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could review policy and procedure and develop a schedule to complete the required assessment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending	21540		4/14/21

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21540	Continued From page 53 physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete a comprehensive sleep assessment to determine the need for sleep aids ordered for insomnia for 1 of 5 residents (R12) reviewed for unnecessary medications. Findings include: R12's admission record revealed R12 was admitted on 9/27/20 with diagnoses of dementia with behavioral disturbance, anxiety and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 11-30-20, indicated R12 did not display behavior problems or difficulty sleeping, feeling tired or having little energy. R12's physician orders included Trazodone 50 MG (milligrams) Give 1 tablet by mouth at bedtime for insomnia/restlessness. The start date for this order was 10/29/2018. R12's care plan did not include non-pharmacological interventions for sleep. R12's medical record lacked evidence of a comprehensive sleep assessment and analysis of sleep monitoring for continued use of Trazodone. R12s physician visit progress note dated 2/1/2021 included," The patient is a pleasant	21540	Corrected.	

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21540	Continued From page 54 92-year-old woman, I am seeing for a routine visit ...denies depression, appetite or sleep problems ..." During an interview on 2/25/21, at 9:03 a.m. the director of nursing (DON) stated she was unable to locate sleep monitoring or a sleep assessment for R12. The DON verified a sleep assessment was completed to help determine justification for continued use of the medication. During an interview on 2/02/25/21, at 5:17 p.m. registered nurse (RN)-A stated sleep assessments would be documented under assessments and if was unable to find one there, would assume a sleep assessment had not been done. RN-A stated sleep assessments should be completed quarterly, annually, with a change of condition and change of sleep. A policy and procedure for sleep assessments was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are updated and that staff training has been completed to assure resident's receiving medications for insomnia have sleep monitored and sleep assessments completed to ensure residents are not taking unnecessary drugs. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21540		
21910	MN St. Statute 144.651 Subd. 25 Patients & Residents of HC Fac.Bill of Rights	21910		4/14/21

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21910	Continued From page 55 Subd. 25. Financial affairs. Competent residents may manage their personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on their behalf if they delegate this responsibility in accordance with the laws of Minnesota to the facility for any period of time. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to keep an accounting of money in the resident funds accounts and failed to keep any resident fund money in an interest-bearing account. This had the potential to affect all 12 residents that had money in a personal fund account with the facility. Findings include: During an interview on 02/25/21, at 12:25 p.m. the administrator and business office manager (BOM) stated 12 current resident had trust accounts and the facility was unable to determine at this time how much money was in each resident account. The BOM stated she was planning to go to the bank to get the deposit slips to figure out how much money was in each account from the bank documentation of deposits. The BOM stated the resident funds were kept in a checking account rather than a saving account. The BOM stated the bank was going to work with her to get money transferred into an interest-bearing account and stated she talked to the bank about that this afternoon. A policy on personal funds accounts was requested and not provided.	21910	Corrected.	

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21910	Continued From page 56 Review of the facility's "Combined Federal and State Bill of Rights [given to the residents and resident representatives during admission]" with the last revision on 11/28/16 revealed under "Self-Determination" "...Deposit of funds...a. The facility must deposit any residents' personal funds in excess of $100 in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) ...b. Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50. In an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)." SUGGESTED METHOD OF CORRECTION: The Administrator could assure that funds that are maintained by the facility in excess of $100.00 and $50.00 for Medcaid residenst are in an interest bearing account. The QAA could randomly audit accounts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21910		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in	21942		4/14/21

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21942	Continued From page 57 participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council during the past calendar year. Findings include: During an interview on 2/24/21, at 12:41 p.m. the director of nursing (DON) stated the facility did not have an active family council. The DON verified there had been no documented attempts by the facility to establish a family council during the past year. A Family Council Policy and Procedure was requested and not provided by the facility. SUGGESTED METHOD OF CORRECTION: The administrator or designee could delegate an individual to be responsible for the annual attempt to establish a family council/group. That individual would need to document it's efforts at forming a council, and identify when the attempt occurred in the calendar year. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21942	Corrected.	

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	245499	A. BUILDING **01 - THE LUTHERAN HOME CALEDONIA** B. WING _____	**02/24/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Caledonia Care and Rehab 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE 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. Health Care Fire Inspections	K 000		

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

Electronically Signed | 03/23/2021

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

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K 000	Continued From page 1 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 description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Caledonia Care and Rehab is a 1-story building. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II(000)construction, with a full basement. In 1971, addition was constructed and was determined to be of Type II(000) construction, with no basement. In 1975, addition was constructed and was determined to be of Type II(000) construction, with no basement. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is divided into four separate smoke compartments. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with	K 000		

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K 000	Continued From page 2 full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 38 at the time of the survey The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper means of egress requirements in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 7.2.1.4.1 and 7.2.1.7. This deficient practice could affect all 49 residents. Findings include: On facility tour at 10:00 AM on 02/24/2021, observations and staff interview revealed the following: During walk-through of the facility observed on the 1st Floor that more than 30 pounds of force	K 211	Adjustments were made to the doorframe by maintenance director filing down a portion of the frame and the door no longer requires 30lbs of force to open. The door was tested and meets the requirement compliantly. Monitoring of this deficiency to mitigate future citation includes education to the Maintenance Director of regulation on door pressure, adding the task of door force to standard building rounds, and 1x/month audit for 12 months on door force. Finds to be reviewed at QAPI for audit continuation. Corrective action completed by 4/14/21	4/14/21

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K 211	Continued From page 3 was needed to open the West exit door. This deficient practice was confirmed by the Facility Maintenance Director and Administrator at the time of discovery.	K 211	Maintenance/Designee is responsible for correction and ongoing compliance.	
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper grade transition at a point of egress in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 7.1.6.2. This deficient practice could affect all 49 residents. Findings include: On facility tour at 10:15 AM on 02/24/2021, observations and staff interview revealed the following: During walk-through of the facility observed on Basement Reverse Floor that the South exit door had a vertical transition to grade of more than 1 inch (sidewalk setting). This deficient practice was confirmed by the Facility Maintenance Director and Administrator at	K 271	Director adjusted the height of the transformation pad to ensure the outdoor transformation pad is level with the doorframe. There is not a greater transition to grade of more than 1/2 inch in the sidewalk setting. This deficient finding has been remedied. Monitoring of this deficiency to mitigate future citation includes education to the Maintenance Director of regulation on egress, adding the task of egress check to standard building rounds, and 1x/month audit for 12 months on egress to occur to ensure there is not a greater transition to grade of more than 1/2” present. Findings to be reviewed at QAPI for audit continuation. Corrective action completed by 4/14/21 Maintenance/Designee is responsible for correction and ongoing compliance.	4/14/21

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	245499	A. BUILDING **01 - THE LUTHERAN HOME CALEDONIA** B. WING _____	**02/24/2021**

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K 271	Continued From page 4 the time of discovery.	K 271		
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 document review and staff interview, the facility failed to maintain and test the fire sprinkler system in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 9.7.5, 9.7.7, and 9.7.8, and the 2011 edition of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient practice could affect all 49 residents. Findings include: On facility tour at 11:45 AM on 02/24/2021,	K 353	The proposed plan to be completed by 4/14/21 includes contacting a sprinkler testing company to complete the necessary sprinkler system testing and to get on a quarterly schedule with their testing services. This effort is to be recorded and kept onsite for reference. Monitoring of this deficiency to mitigate future citation includes adding this quarterly task to the Maintenance Director's list of responsibilities and 1x/month audit for 1 year to ensure sprinkler testing is occurring at least	4/14/21

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K 353	Continued From page 5 documents review and staff interview revealed the following: During documentation review no records were provided to confirm that the facility had completed -or- vendor contracted, quarterly inspections of the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director and Administrator at the time of discovery.	K 353	quarterly. Findings to be reviewed at monthly QAPI for audit continuation. Corrective action completed by 4/14/21 Maintenance/Designee is responsible for correction and ongoing compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, documents review and staff interview, the facility failed to maintain, inspect and test doors in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 19.3.6.3.3, 19.3.6.3.5 and 8.3.3.1 and the 2010 edition of NFPA 80, Standard for Fire Doors and Other Opening Protectives, sections 5.2, 5.2.3	K 761	The proposed plan to be completed by 4/14/21 includes tightening the hinge and buying a spring to ensure the door appropriately self-latches. The spring was installed on 3/25 and the door latches appropriately. The proposed plan to be completed by	4/14/21

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K 761	Continued From page 6 2010 NFPA 80. This deficient practice could affect all 49 residents. Findings include: On facility tour at 10:30 AM on 02/24/2021, observations, documents review and staff interview revealed the following: 1) During walk-through of the facility observed on the Basement Floor that the Elevator Machine Room door, when tested, did not properly self-close and latch to secure the room 2) During documentation review no records were provided to confirm that the facility had completed -or- vendor contracted, annual maintenance, inspection, and testing of doors This deficient practice was confirmed by the Facility Maintenance Director and Administrator at the time of discovery.	K 761	4/14/21 includes the maintenance, inspection, and testing of doors. Negative findings will be remedied accordingly to needs. The facility plans to complete this task in-house and will record and keep findings onsite for reference. Monitoring of this deficiency to mitigate future citation includes educating the Maintenance Director on this requirement, adding this annual task to the Maintenance Director's list of responsibilities, and 1x/quarter audit for 1 year to ensure that doors are maintained, inspected, and tested within the facility with records available. Findings will be reviewed and QAPI for audit continuation. Corrective action completed by 4/14/21 Maintenance/Designee is responsible for correction and ongoing compliance.	
K 912 SS=F	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced	K 912		4/14/21

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K 912	Continued From page 7 by: Based on document review and staff interview, the facility failed to complete annual testing of electrical outlets in resident rooms in accordance with the Healthcare Facilities Code, NFPA 99-2012, sections 6.3.4.1.3. This deficient practice could affect all 49 residents. Findings include: On facility tour at 11:00 AM on 02/24/2021, documents review and staff interview revealed the following: During documentation review no records were provided to confirm that the facility had completed -or- vendor contracted, annual electrical receptacle testing. This deficient practice was confirmed by the Facility Maintenance Director and Administrator at the time of discovery.	K 912	The proposed plan to be completed by 4/14/21 includes electrical receptacle testing in reach resident room and for every outlet. This effort is to be recorded and kept onsite for reference. Monitoring this deficiency to mitigate future citation includes adding this annual task to the Maintenance Director's list of responsibilities and 1x/quarter audit for 1 year to ensure the electrical receptacles in resident rooms are tested at least annually. Findings to be reviewed at monthly QAPI for audit continuation. Corrective action completed by 4/14/21 Maintenance/Designee is responsible for correction and ongoing compliance.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of	K 923		4/14/21

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K 923	Continued From page 8 noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper separation of med gas (O2) cylinders in accordance with the Health care Facilities Code, NFPA 99-2012, section11.6.5.2. This deficient practice could affect all residents within the smoke compartment. Findings include: On facility tour at 11:15 AM on 02/24/2021, observations and staff interview revealed the following:	K 923	Oxygen cylinders (empty/full) were separated appropriately and the facility is compliant with the regulation. Monitoring this deficiency to mitigate future citation includes: adding this task to the Maintenance Director's list of weekly responsibilities, clear labeling within the oxygen storage area for empty and full cylinders/containers, staff education on expectation for cylinder storage, ongoing monitoring of recorded 2x/week audits for 1 month with re-education to follow as appropriate. Findings to be reviewed at monthly QAPI for audit continuation.	

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K 923	Continued From page 9 During walk-through of the facility observed on the 1st Floor the Med Gas Room had mixed storage of O2 cylinders (empty/full) This deficient practice was confirmed by the Facility Maintenance Director and Administrator at the time of discovery.	K 923	Corrective action completed by 4/14/21 Maintenance/Designee is responsible for correction and ongoing compliance.	