



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 31, 2023

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: February 23, 2023

Dear Administrator:

On March 14, 2023, we notified you a remedy was imposed. On March 29, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 27, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 29, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 14, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 29, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 27, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 2023

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

Re: Reinspection Results
Event ID: 5T6T12

Dear Administrator:

On March 29, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 23, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



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March 14, 2023

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

RE: CCN: 245028
Cycle Start Date: February 23, 2023

Dear Administrator:

On February 23, 2023, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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 March 29, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 29, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 29, 2023.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 29, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Highland Operations LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 29, 2023. 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.

Highland Operations LLC

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- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor

Metro 1, Golden Rule Office

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

85 East Seventh Place, Suite 220

P.O. Box 64900

Saint Paul, Minnesota 55164-0900

Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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

Highland Operations LLC

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Services that your provider agreement be terminated by August 23, 2023 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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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/ltr_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.

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us



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March 14, 2023

Administrator
Highland Operations LLC
2319 West Seventh Street
Saint Paul, MN 55116

Re: State Nursing Home Licensing Orders
Event ID: 5T6T11

Dear Administrator:

The above facility was surveyed on February 15, 2023 through February 23, 2023 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

Highland Operations LLC

March 14, 2023

Page 2

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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/23/2023
NAME OF PROVIDER OR SUPPLIER HIGHLAND OPERATIONS LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 2/15/23 through 2/23/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H50288314C(MN90972) and H50288309C(MN90979) with a deficiencies issued at F550, F656, F676, F689, F689, F692, F697, and F921. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		3/27/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/17/2023

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

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F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively identify a resident's actions, behaviors, and motives for 1 out of 3 residents (R2) reviewed for dignity when R2 self-identified he needed more help, staff stated R2's toenails looked "scary" and painful, R2 had multiple clothing changes, was often naked, his room was a mess, R2 "smelled",	F 550			
			R 2 toenails were trimmed on 2/24/2023. A new bowel and bladder screener was completed and from this assessment a toileting plan will be developed and implemented. R2's bathing schedule was reviewed and R2 received a bath on 3/14/2023. R2 ADLs (bathing, dressing, toileting, eating, transferring was reviewed		

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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 550	Continued From page 2 and R2 stated staff treated him "carelessly". Findings include: During observation and interview on 2/16/23, at 9:16 a.m. R2 was in his room sitting in his wheelchair naked. R2's soiled clothing were found on the floor. He said he took his pajamas off because it was wet. He started to look around the room and found a blanket to cover himself. He said he was embarrassed. R2 stated he preferred to wear clothing and he did not like to sit in wet clothes. He stated the staff's treatment made him feel not "human." In addition, he said nursing staff yell and laugh at him, and he begs his family to take him home. R2's toenails were thick, dry, and extended away from his toes at various lengths up to one inch. R2 rated his toenail pain at a 7 out of 10 (a numerical pain rating scale from zero being no pain, ten being the worst pain.) Family member (FM)-A stated the staff are not cutting R2's fingernails and toenails. He stated the poor nail care has caused R2 to suffer increased pain. FM-A stated when he visited on 2/15/23, R2 told him his toes hurt and FM-A helped remove his shoes. FM-A stated he did not know what to do about the long nails, and unsure if he would have to bring R2 somewhere to get them cut. In addition, he had dried blood on his wander guard. He also had an unkempt, thick facial hair covering his lower face. R2 stated he asked the nursing staff to cut his nails and facial hair but "they won't do it." R2 stated he always preferred a clean-shaven face. Pictures of R2 hanging in his room at various ages showed a clean-shaven face with a mustache. FM-A stated R2 was very picky about the clothes he wore, and always had a clean-shaven face. He added R2 would never wear dirty clothes	F 550	and updates to the level of care were implemented. All existing residents were reviewed for podiatry services and ADL care were reviewed and updates were made as needed. Future residents will be assessed upon admission and ancillary services and ADL care will be rendered per the resident plan of care. Facility staff was in-serviced on the entire Resident Rights policy and procedures with emphasis on item #1b that all residents are to be treated with dignity and respect. Social Services and/or designee is responsible for compliance. Audits on ADL care completion, podiatry services and ADL care plan updates will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 3/27/2023		

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F 550	Continued From page 3 During observation on 2/16/23, at 12:06 p.m. R2 was sitting in the dining room with a piece of paper towel covering his left hand to cover his face. Later during the observation R2 was sleeping in his wheelchair next to a dining room table with his shoes off and placed on the floor next to him. Nursing assistant (NA-C) walked up to R2 and told him he was at the wrong table. Without waiting for R2 to respond she unlocked the wheelchair brakes and pushed him to a different table. She then returned to R2's shoes and picked them up. She walked towards his wheelchair and stopped approximately seven feet from him. She then threw his shoes toward R2 striking the side of the wheelchair. R2's food tray was placed in front of him. The staff did not set up his meal tray, remove the covers from the food or ask if R2 wanted any condiments. R2's annual Minimum Data Set (MDS) dated 12/27/22, identified R2 was able to understand communication but had unclear speech. R2 did not refuse or reject cares from staff. R2 could move independently in bed but needed one staff member to help him transfer from one surface to another and walk in his room or around the unit. He needed extensive assistance from one staff member to dress and complete hygiene needs. In addition, he required supervision when he used the bathroom and toilet. R2's care conference note dated 1/12/23, identified R2 told the staff he needed more help. R2's patient health questionnaire-9 (PHQ-9) dated 2/10/23, identified R2 told social services (SS)-A the nursing staff treat him "carelessly" and their actions had worsened his depression. He	F 550			

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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 550	Continued From page 4 was not able to provide more information about the staff, specific incidents or how their actions caused him to be more depressed. R2's face sheet and his electronic medical record (ERM) picture dated 2/16/23, was a view of him not wearing clothing from his head to nipple line. This face sheet would be handed to transport companies, clinic, and hospital staff. In addition, any facility staff who utilized the EMR system was able to visualize R2 without his shirt on. During interview on 2/15/23, at 3:53 p.m. Department of Human Services (DHS)-A stated he visited resident R2 on 2/8/23, to conduct a survey for the Department of Human Services. When he asked R2 about the care he received from the staff he started to "profusely cry." A photo was taken by DHS-A on 2/8/23, during his interview when he observed a wash basin on the floor under his bed. R2 told him he used the basin to urinate in when he was in bed. Additional photos included pictures of his room in disrepair, dirty living space, piles of dirt and various of items under his bed, and up against the wall. During interview on 2/17/23, at 11:37 a.m. nursing assistant (NA)-A stated she took care of R2 on 2/16/23, and he "smelled" so she gave him an extra shower. She attempted to cut his nails but the nail trimmers at the facility were too small. NA-A stated his toenails "look scary" and must cause pain when he wore shoes. She stated R2 does not like to wear dirty clothing and will change into clean clothes often during the day. During interview on 2/17/23, at 11:47 a.m. housekeeper (H)-A stated R2 would put his clothing and bed linen on the floor all the time.	F 550			

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F 550	Continued From page 5 She added there is always paper toweling on the bathroom floor and by the next day the dispenser would be empty. She said he changes his clothing so often they have to do his laundry every day. She added the nursing staff would place his clean clothing on a shelf in the equipment room so he would be unable to change his clothes when wet. H-A stated he will move his bed and dressers around the room. She did not know why he did it. She said he "does not listen" when she told him not to mess up his room During interview on 2/21/23, at 4:30 p.m. the director of nursing (DON) stated the picture of R2 on the face sheet and in the EMR was inappropriate and undignified and she did not know why staff would have taken the picture of him undressed. The Dignity policy dated 12/8/21, identified all residents would be treated by staff with dignity and respect. Staff would respect residents' individual preferences, values, and beliefs. Staff would assist the resident to complete hygiene and grooming activities such as facial hair and nail care. Residents will receive a "dignified" dining experience. Staff would identify residents' behavior by finding the root cause and motives. Staff would never challenge a resident's beliefs or talk to them in a demeaning manner.	F 550			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656			3/27/23

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F 656	Continued From page 6 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656			

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F 656	Continued From page 7 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a person-centered care plan to maintain a resident's highest practicable physical, mental, and psychosocial well-being for 1 of 1 resident (R2) reviewed for care plans. R2's lacked interventions for bladder incontinence and communication. During observation and interview on 2/16/23, at 9:00 a.m. R2 had difficulty communicating his needs and concerns. R2 had no communication tools, to make his needs known. There was no communication board in his room, and when offered a pen and paper to write down his thoughts he shook his head no. R2 had weakness, and partial paralysis on his left side making it difficult for him to write. R2 unable to answer open ended questions, could respond yes or no with a nod to verify and clarify responses. R2's care plan revised 10/19/22 indicated R2 has impaired communications, potential for communication impairment, neurological symptoms. R2's goal was to improve communication by using appropriate gestures and responding to yes or no questions. Staff interventions were to anticipate and meet R2's needs, ask yes or no questions, allow adequate time to respond repeat questions, do not rush, clarify understanding, face R2 and make eye contact, use simple brief words and/or cues, use alternative communication tools. R2's care plan did not identify alternate communication tools. R2's annual Minimum Data Set (MDS) dated	F 656	R2 entire care plan was reviewed and updated to include R2's current urinary status and communication methods. All existing residents who are identified with psychosocial well being concerns with communication and urinary focuses care plans were reviewed and updated as needed. Future residents will have a comprehensive person-center care plan created and implemented per the facility policy. Licensed nurses will be in-serviced on the comprehensive care plan policy and procedures with emphasis on item #3 that the care plan is designed to identify resident strengths, weaknesses and preventing declines in resident function. Director of Nursing and/or designee is responsible for compliance. Audits on comprehensive care plan creation with appropriate care plan interventions will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 3/27/2023		

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F 656	Continued From page 8 12/27/22 indicated R2 was cognitively intact and was able to understand, but his speech was unclear, slurred, and he mumbled his words. He had Parkinson's disease, dementia, malnutrition, depression, Dysphagia (impaired ability to swallow), and repeated falls. R2's MDS identified care area assessments and care planning areas for R2: urinary incontinence and/or indwelling catheter, falls, nutritional status, dental care, and pressure ulcers. R2 nor R2's family or representative participated in the comprehensive assessment and goal setting. R2's quarterly MDS dated 2/10/23 indicated R2 nor R2's family or representative participated in the comprehensive assessment and goal setting. R2's care plan initiated 1/31/23 indicated R2 was incontinent of bladder, neurogenic disorder, the goal was R2 would continent during waking hours, staff interventions were to "Check (specify freq) and as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes." R2's care planned interventions to keep R2 continent were not person centered as R2 urinated in containers in his room and his clothing was often wet. During interview on 2/15/23, at 3:53 p.m. Department of Human Services (DHS)-A stated he visited resident R2 on 2/8/23, to conduct a survey for the Department of Human Services. When he asked R2 about the care he received from the staff he started to "profusely cry." A photo was taken by DHS-A on 2/8/23, during his interview when he observed a wash basin on the floor under his bed. R2 told him he used the basin to urinate in when he was in bed. Additional photos included pictures of his room in disrepair,	F 656			

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F 656	Continued From page 9 dirty living space, piles of dirt and various of items under his bed, and up against the wall. During interview on 2/16/23, at 9:16 with R2's family member (FM)-A stated he had a hard time understanding his brother. He stated R2 was unable to physically write down his thoughts on paper. He stated R2 did receive speech therapy when he first arrived at the facility, but he no longer qualified for further treatment. He stated R2 was never presented with a communication board (a list of symbols or pictures to help identify needs when unable to speak clearly.) During interview on 2/17/23, at 10:57 a.m. physical therapist (PT)-A stated R2 was assessed by a speech therapist and reminded him to speak clearly, and slowly. She stated the staff who work with him can understand his needs. She added the facility had communication boards but did not present one to R2 because they wanted him to practice his speech. In addition, she did not know if he would even use it to communicate his needs. During interview on 2/17/23, at 11:37 a.m. nursing assistant (NA)-A said she struggled to understand R2 and was unable to think of any strategies or communication tools to help him communicate his needs. During interview on 2/17/23, at 12:50 p.m. RD-A stated he had a hard time understanding R2 and he would limit the conversation to yes or no questions. During interview on 2/21/23, at 3:58 p.m. nursing assistant (NA)-D stated she had a hard time understanding R2. She was trained to ask him yes and no questions and reminded him to speak	F 656			

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F 656	Continued From page 10 slowly. She confirmed R2 did not have a communication board in his room. During interview on 2/21/23, at 4:30 p.m. the director of nursing (DON) stated staff were able to understand R2 if they reminded him to slow down. She did not feel at this point R2 needed a communication board to promote communication. The facility police titled Care Plans, Comprehensive Person-Centred undated version 1.3 indicated each resident ' s comprehensive person-centered care plan will be consistent with the resident ' s rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; b. identify individuals or roles to be included; c. request meetings; d. request revisions to the plan of care; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care; g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made. 7. The care planning process will: a. facilitate resident and/or representative involvement; b. include an assessment of the resident ' s strengths and needs; and c. incorporate the resident ' s personal and cultural preferences in developing the goals of care. 8. The comprehensive, person-centered care plan will: a. include measurable objectives and timeframes;	F 656			

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F 656	Continued From page 11 b. describe the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being; c. describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; d. describe any specialized services to be provided as a result of PASARR recommendations; e. include the resident ' s stated goals upon admission and desired outcomes; f. include the resident ' s stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. incorporate identified problem areas; h. incorporate risk factors associated with identified problems; i. build on the resident ' s strengths; j. reflect the resident ' s expressed wishes regarding care and treatment goals; k. reflect treatment goals, timetables and objectives in measurable outcomes; l. identify the professional services that are responsible for each element of care; m. aid in preventing or reducing decline in the resident ' s functional status and/or functional levels; n. enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. reflect currently recognized standards of practice for problem areas and conditions. 9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes,	F 656			

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F 656	Continued From page 12 and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a. No single discipline can manage an approach in isolation. b. The resident ' s physician (or primary healthcare provider) is integral to this process. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident. 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change. 14. The interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident ' s condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. continues on next page	F 656			
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive	F 676			3/27/23

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F 676	Continued From page 13 assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor, assess, and	F 676			
			R 2 toenails were trimmed on 2/24/2023. R 2 was assessed for pain and also had a		

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F 676	Continued From page 14 intervene to reduce the risk for developing long, dry, and thick toenails, and facial hair growth for 1 of 3 residents (R2) who was reviewed for activities of daily living when R2 stated his long toenails caused increased pain when he wore shoes, and he wanted his face clean shaven every day. Findings include: During interview and observation on 2/16/23, at 9:16 a.m. R2 was in his room sitting in his wheelchair naked. R2's soiled clothing and shoes were found on the floor. R2's toenails were thick, dry, and extended away from his toes at various lengths up to one inch. He also had scraggly thick facial hair covering his lower face. R2 stated he asked the nursing staff to cut his nails and facial hair but "they won't do it." R2 stated he always preferred a clean-shaven face. Pictures of R2 hanging in his room at various ages showed a clean-shaven face with a mustache. R2 rated his toenail pain at a 7 out of 10 (a numerical pain rating scale from zero being no pain to ten being the worst pain.) During observation on 2/16/23, at 12:06 p.m. R2 was in the dining room sleeping in his wheelchair. He did not have socks on, and his shoes were off, and laying in front of the wheelchair. R2's care plan dated 10/18/22, identified he needed limited staff assistance to complete hygiene and oral care. In addition, R2 required limited assistance from one staff member to help complete personal hygiene and oral cares. R2's annual Minimum Data Set (MDS) dated 12/27/22, identified R2 was able to understand	F 676	new pain assessment completed. All existing resident toenails were assessed and trimmed by facility staff. Existing residents will be assessed by the contracted podiatry service on tentative pending new contract. Future residents will be assessed upon admission for nail care and will be scheduled for podiatry services as needed and per resident preference. Nursing staff were in-serviced on the Foot Care and Foot Care Procedure with focus on providing nail care to prevent infection and keeping nails trimmed and nail beds clean. Director of Nursing and/or designee is responsible for compliance. Audits on nail care trimming will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 3/27/2023		

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F 676	Continued From page 15 communication but had unclear speech. R2 did not refuse or reject cares from staff. R2 could move independently in bed but need one staff member to help him transfer from one surface to another and walk in his room or around the unit. He needed extensive assistance from one staff member to dress and complete hygiene needs. In addition, he need supervision for toileting. R2's nursing assistant (NA) task sheet dated 1/1/23, through 1/31/23, identified he would receive hygiene assistance on every shift while awake. R2 had 15 days during the month when staff documented completed personal hygiene on both the day and evening shift. R2 had five days during the month when staff documented personal hygiene completed only on the day shift. R2 had five days during the month when staff documented personal hygiene completed only on the evening shift. R2 had six days during the month when there was no documented personal hygiene for the whole day. R2 was not hospitalized during these time frames to explain the omission of care. During interview on 2/16/23, at 9:16 a.m. family member (FM)-A stated the staff are not cutting R2's fingernails and toenails. He stated the poor nail care has caused R2 to suffer increased pain. FM-A stated when he visited on 2/15/23 R2 told him his toes hurt and he helped to remove his shoes. FM-A stated he did not know what to do about the long nails, and unsure if he would have to bring R2 somewhere to get them cut. FM-A stated R2 was very picky about the clothes he wore, and always had a clean-shaven face. He added R2 would never wear dirty clothes. During interview on 2/17/23, at 11:37 a.m. nursing	F 676			

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F 676	Continued From page 16 assistant (NA)-A stated she took care of R2 on 2/16/23, and he "smelled" so she gave him an extra shower. She attempted to cut his nails but the nail trimmers at the facility were too small. NA-A stated his toenails look "scary" and must cause pain when he wore shoes. She stated R2 does not like to wear dirty clothing and will change into clean clothes often during the day. During interview on 2/21/23, at 1:03 p.m. nurse practitioner (NP)-A stated she was aware of R2's long toenails and she asked the assistant director of nursing (ADON) when the podiatrist would visit the facility next. She was told the podiatrist no longer came to the facility. During interview on 2/21/23, at 4:30 p.m. the director of nursing (DON) stated she assessed R2's toenails and did not think she could safely cut them. She stated the podiatrist comes to the facility monthly and R2 was placed on the list to be seen. She added the last two months the podiatrist was unable to come to the facility related to the winter weather alerts. The DON called the podiatrist and requested an earlier visit day but was unable to get him to the facility sooner. She agreed the long thick toenails would cause R2 increased painful. The Activities of Daily Living (ADLs), Supporting policy dated 12/7/21, stated residents would receive nursing care to promote and maintain nutrition, grooming and hygiene. The residents' ability to complete ADLs would be documented in the care plan to include bathing, dressing, grooming and oral cares. To prevent further decline, staff would assess pain management, and treatment for depression if appropriate. If a resident declined hygiene care, staff would	F 676			

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F 676	Continued From page 17	F 676			
F 689 SS=G	reapproach at a different time , using different staff members. Extensive assistance involved the level of resident's ability to complete the hygiene tasks while the staff provided weight-bearing support. Staff would monitor and re-evaluate the resident's abilities and update the care plan as needed. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate 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 fall risk factors, implement effective fall prevention strategies, and re-evaluate the fall interventions effectiveness to prevent falls for 1 of 3 residents (R2) reviewed for falls when R2 suffered multiple falls since 11/17/22 resulting in injuries and hospitalization. Findings include: During observation on 2/16/23, at 1:15 p.m. R2 stood up from his wheelchair and began walking down a hallway different from the one his room was on. His gait was unbalanced, and he appeared to be walking side to side on his toes not the balls of his feet. He walked approximately 10 feet before the NA-C who was sitting on the	F 689	R2 had a new fall and pain assessment completed. R2 also had a risk management incident created for the near miss fall during the facility survey and this incident was thoroughly reviewed and a new intervention was initiated. R2's NP was contacted to review resident current medications and to adjust as needed. Existing resident falls from survey exit until present will be reviewed, thoroughly investigated for a root cause and new interventions added as needed. Future resident falls will have a new fall and pain assessment completed and the incident reviewed thoroughly, and interventions implemented. Nursing staff were in-serviced on the Fall Clinical Protocol with emphasis on the		3/27/23

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F 689	Continued From page 18 other side of the dining room saw him. He was already down the hallway when she caught up to him. She ran back to the dining room to grab his wheelchair. A few minutes later she pushed him in his wheelchair back to the dining room, locked his wheelchair and walked away. He was not wearing shoes at the time of the incident. R2's care plan dated 8/17/22, identified he had a risk for falling related to his poor balance and an unsteady gait. Interventions included a pharmacist review to identify potential medication interactions affecting his gait and stability . In addition, staff would continue to monitor and encourage him to use his assisted devices (wheelchair or walker) when he was up moving around his room and the unit. R2's care plan dated 9/12/22, identified staff were to keep the wheelchair's footrests (a movable footplate extending outward in front of the wheelchair) off to prevent tripping and monitor him to ensure he is sitting in the chair. In addition, staff were instructed to encourage him to keep his wheelchair or walker close by when he gets up to move about his room and unit. R2's fall therapy assessment dated 11/16/23, identified he was impulsive and had "poor safety awareness" leading to frequent falls. R2's witnessed fall report dated 11/17/22 indicated R2 fell in the hallway, 2nd floor west. R2 fell trying to go outside to smoke. R2 was walking behind, pushing his wheelchair. R2 was assessed and reminded to sit in the wheel when using and ask for assistance when needed. R2 was not injured.	F 689	entire policy but additional focus on the treatment and management section item #2 that if falls continue after several interventions, until the reason for falls are identified for its continuation. Director of Nursing and/or designee is responsible for compliance. Audits on fall incident root cause and fall intervention creation timely will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 3/27/2023		

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F 689	Continued From page 19 R2's nursing progress note dated 11/17/22, at 2:36 p.m. identified he fell to the ground while he pushed his wheelchair through the main facility door on his way out to smoke a cigarette. He required staff assistance to get up. He denied suffering an injury from the fall. R2's witnessed fall report dated 11/19/22 indicated R2 fell in R2's room, 2nd floor west. R2 fell while coming out from the bathroom. R2 was in bed and bleeding from the right eye. R2's nursing progress note dated 11/19/22, at 2:20 a.m. identified when he walked out of his bathroom he fell to the ground. He sustained a laceration by his right eye causing bleeding at the site. R2 was transferred to the hospital's emergency room for evaluation and treatment. R2's nursing progress note dated 11/19/22, at 2:07 p.m. identified the emergency room treated his laceration with five stitches. He returned to the facility the same day. R2's nurse practitioner (NP)-A's visit note dated 11/21/23, identified the purpose for the visit was to follow up on "yet" another fall. NP-A stated it would be a benefit for R2 if he had transferred to a memory care unit where a facility would have more staff to provide additional care and monitoring. R2's NP-A's visit note dated 11/22/23, identified the purpose for the visit was to assess his right knee wound caused from a fall. In addition, NP-A identified R2 continues to have multiple falls at the facility. R2's witnessed fall report dated 11/24/22	F 689			

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F 689	Continued From page 20 indicated R2 fell in the hallway, 2nd floor west. The incident description indicated R2 was calling for help. Staff arrived and found R2 on the floor with his wheelchair tipped over. R2 was pushing his wheelchair. R2 was assessed and had no injuries. R2's nursing noted on 11/28/22, at 9:47 p.m. identified the resident was "restless, impulsive and noncompliant with directions." R2 fell in his room and his upper right eye lid was bleeding. His medical provider was notified about the fall and placed an order for the facility to send him to the hospital for an evaluation. R2's witnessed fall report dated 12/3/22 indicated R2 fell in R2's room, 2nd floor west. The incident description indicated R2 was yelling for help in his room. Staff arrived and four R2 lying on the floor face down in the bathroom with his legs in the room. R2 was sent to the hospital. R2's nursing note on 12/3/23, at 11:03 a.m. identified he fell on the floor in his room. He was found lying halfway in the bathroom face down. R2 was confused and complained of a headache. Nursing staff updated the NP and received orders to send him to the emergency room for an evaluation. R2's hospital discharge document on 12/8/23, identified he was admitted to the hospital on 12/5/22, for "severe malnutrition" (when the daily protein intake is less than their body's daily requirement) and low blood glucose levels (when blood glucose levels drop below 70 and cause blurred vision, confusion, slurred speech, and drowsiness. If the condition is not treated the brain would be starved from a lack of glucose	F 689			

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F 689	Continued From page 21 leading to seizures, coma, and death.) R2 had a recent hospital visit on 11/22/22, for a vulnerable adult assessment, on 11/28/22, "again" for frequent falls, and on 12/3/22, after "another" unwitnessed fall leading to a closed head injury (when the brain is injured from a rapid forward or backward movement up against the skull leading to a bruise or tearing of the brain tissue.) While he was hospitalized the nursing staff identified he had poor balance, decreased low extremity (legs) strength, and was not safe to walk independently. The recommended hospitals' plan for discharge after his nutrition and blood sugar levels improved was to transfer him to a memory care unit. R2's facility's nurse admission and readmission document dated 12/9/23, identified he had a recent hospitalization related to a fall. R2 was found impulsive and required staff's physical assistance to get up. R2's physical therapy (PT) evaluation and plan of treatment dated 12/10/22, identified he had a lack of ability to identify risky situations. In addition, he had a Parkinson's disease gait (when the body leans forward causing him to take rapid, small steps in attempt to maintain his center of gravity.) R2 required partial or moderate assistance to stand up, transfer from bed to a chair, and to use the toilet. R2's nursing note dated 12/14/23, at 4:06 a.m. identified he was sitting on the floor with his head resting against the seat of his wheelchair. R2 was incontinent of urine at the time of the fall and reported a headache. R2's fall risk summary dated 12/14/23, identified	F 689			

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F 689	Continued From page 22 he had a high risk for falls. R2's NP-A visit summary on 12/15/22, identified an order to "Please place on fall precautions and monitor patient routinely." R2's nursing progress note dated 12/26/22 at 9:25 p.m. identified R2 fell around 7:00 p.m. in the dining room injuring his head and left shoulder. Staff identified a "scrape" on the top of his left shoulder, and he complained about both of his shoulders hurting. R2 received "pain" medication and NP-A was notified about the incident and she ordered an Xray of the left shoulder. R2's annual Material Data Sheet (MDS) dated 12/27/22, identified R2 was able to understand conversations, but had difficulty speaking. There was no history of R2 rejecting cares from staff. R2 had malnutrition, Parkinson's disease, history of falls, dysphagia, muscle weakness, dementia, CVA (cerebral vascular accident also referred to as a stroke), anxiety, orthostatic hypotension (his blood pressure dropped when he stood up causing lightheadedness), high blood pressure and depression. R2 could move independently in bed but needed one staff member to help him transfer from one surface to another and walk. He needed extensive assistance from one staff member to dress and complete his hygiene needs. In addition, he only needed staff supervision (oversight, encouragement, or cues) and set up help when he used the toilet. R2's neurology after summary visit note on 1/19/23, at 11:00 a.m. identified a referral made for PT to evaluate him for falls and develop preventative interventions.	F 689			

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F 689	Continued From page 23 R2's nursing progress note on 1/26/23, at 3:15 p.m. identified he had an unwitnessed fall. He did not sustain an injury from the fall and the NP, and his family were updated about his condition. R2's medical follow up appt dated 1/30/23, at 9:54 a.m. identified R2's gait was unstable, and he was unable to get up without physical assistance. R2's care plan dated 1/31/23, identified a goal for him to be continent of urine and bowel during waking hours. The only intervention listed was for staff to check him for incontinence. The space for "SPECIFY REQ" where the staff would know how often and when they should check him was left blank. R2's PT functional assessment (a test designed to determine a resident's level of functioning and ability to complete various tasks safely) dated 2/1/23, identified his self-care functioning score was zero (on a score between 0-12, in which 12 being the highest score.) R2's witnessed fall report dated 2/10/22 indicated R2 fell in R2's room, 2nd floor west. The incident description indicated staff were passing by R2's room when the R2 was walking in the room and fell forward by his bedside. R2 was assessed and monitored. R2 had a bruise to his left shoulder. R2's nursing progress note dated 2/10/23 at 11:52 a.m. identified he was found by the housekeeper in his room on the floor trying to get up. In addition, he "sustained a small cut on his left forehead."	F 689			

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F 689	Continued From page 24 R2's resident fall risk assessment dated 2/10/23, identified he had a high risk for falling and required staff assistance and a mobility device such as a walker or wheelchair to ambulate. In addition, R2 received a medication known to cause an increased confusion and alertness. R2's bowel and bladder program screener dated 2/10/23, identified he was "never" able to use the toilet independently without being incontinent (the inability to control the flow of urine). He required the assistance from one person to get into the bathroom and transfer safely to the toilet. The assessment summary identified he was not a candidate for bladder training. R2's witnessed fall report dated 2/12/23 indicated R2 fell in the dining room, 2nd floor west. The incident description indicated R2 was using his wheelchair as a walker. The resident tried to sit in the wheelchair but did not put on the breaks and fell. R2 was assessed and encourage the resident to put on the brakes before sitting in the wheelchair. R2 was not injured. R2's occupational therapy evaluation dated 12/12/22, identified he had impaired balance, poor coordination, unsteady gait, poor problem-solving skills and the inability to assess for environmental hazards. R2's medical providers after visit summary on 2/13/23, identified he had a recent fall, and required sutures to a facial laceration. During interview on 2/15/23, at 3:53 p.m. Department of Human Services (DHS)-A stated he visited resident R2 on 2/8/23, to conduct a survey for the Department of Human Services.	F 689			

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F 689	Continued From page 25 When he asked R2 about the care he received from the staff he started to "profusely cry". R2 told him about a recent fall where he hurt his shoulder. R2 ask the staff for pain medication, and they told him he could not have any at that time and instructed him to lay down in bed. R2's NP-A visit note on 2/15/23, identified the purpose for her visit was to evaluate and treat his left eyebrow laceration from a fall. She identified R2 was "very, very, very impulsive" and fell at the facility many times. In addition, she suggested to the facility "several times" he needed to transfer to a memory care unit for "his safety." R2's NP-A visit note on 2/16/23, identified the purpose for her visit was at the request from the nursing staff related to his complain of left shoulder pain. She ordered fall precautions and to continued routine monitoring. R2's care plan was not updated and did not reflect any new interventions to reduce the risk of falls or re-evaluate the fall interventions effectiveness to prevent falls R2's care plan had two staff interventions: ensure R2 is in his chair and continue to keep assistive devices close when ambulating. During interview on 2/16/23, at 9:16 a.m. FM-A stated R2 fell at least once a week. FM-A stated he is getting weaker, and he was falling because he cannot get any help. R2 knows how to use his call light but when he is in a wheelchair, he cannot reach it. Observed his call light mounted on the wall about four feet above his bed. In addition, the push button call light extending from the wall mount was on the floor behind his bed. R2 was naked and observed both of his	F 689			

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F 689	Continued From page 26 shoulders had various wounds at different stages of healing. In addition, he had scabs on both of his knees. R2's toenails were thick, dry, and extended away from his toes at various lengths up to one inch. He was not wearing shoes and stated the shoes cause pain when his nails rubbed up against it. His wheelchair was not in the room or hallway. There were two walkers in his room, both were folded up, one was placed in his closet and the other one was wedged between the window and his dresser. During interview on 2/16/23, at 12:32 p.m. the administrator stated R2 only fell in the hallway because he was very impulsive not in his room. During interview on 2/17/23, at 11:37 p.m. nursing assistant (NA)-A stated R2 can stand and turn but if staff are not with him, he would fall down. During an interview on 2/21/23, at 1:45 p.m. NP-A stated she assessed him on 2/16/23. She stated given the number of falls he had it is not OK for him to toilet himself without help. she stated it has been frustrating trying to work with the staff and leadership regarding the amount of falls he had endured. She stated at one point she had him on a list to transfer to a higher level of care at a memory care unit, but the facility cancelled the transfer. She feels R2 it's not an appropriate patient for that facility because of his wandering and falls but the facility did not agree with her assessment and canceled the transfer. She stated the facility will not collaborate with her to develop a plan of care and interventions to prevent falls. She has arranged several meetings with the administration to discuss the situation and they failed to show up for the appointment.	F 689			

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F 689	Continued From page 27 The Falls Clinical Protocol dated 10/4/21, identified the staff and medical providers would work together to identify why a resident would continue to fall and document their findings in the resident's medical record within 90 days. Falls would be categorized by the event leading up to the fall. For an example, getting up from a seated position, or trying to walk. If a resident continued to fall despite the interventions set in place, the medical provider would identify any associated medical causes to the fall. The medical provider would evaluate the resident's gait, balance, and medication side effects. If the resident continues to fall despite the attempts to prevent a fall, staff will continue to assess, and develop new interventions until the incidents of falls are reduced or eliminate. Preventing repeated falls are essential related to frail elderly residents have a greater risk for serious adverse reactions after a fall.	F 689			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692			3/27/23

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F 692	Continued From page 28 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess, monitor, an re-evaluate weight loss, the ability to swallow, hydration, appropriate diet consistency, an allergy to shellfish and the need for adaptive equipment, for 1 of 3 residents (R2) assessed for nutrition, weight loss, protein malnutrition (when the daily protein intake is less than their body's daily requirement), and the ability to eat independently. Findings include: During observation on 2/16/23, at 12:06 p.m. R2 was sleeping in his wheelchair next to a dining room table with his shoes off and laying on the floor next to him. A staff member walked up to R2 and told him he was at the wrong table. Without waiting for R2 to respond she unlocked the wheelchair brakes and pushed him to a different table. She then returned to R2's shoes and picked them up. She walked towards his wheelchair and stopped approximately seven feet from him. She then threw his shoes at the wheelchair hitting the side of the chair before falling to the floor. R2's food tray was placed in front of him. The staff did not set up his meal tray by removing the covers from the food or asked if he wanted any condiments. His food tray contained two glasses of milk, one glass of water and one glass of juice. First R2 grabbed two	F 692	R2 was screened and assessed by the therapy department for adaptive eating utensils on 2/20/2023 and swallowing concerns on 02/15/2023. The facility dietitian reviewed the resident current weight and recommendations were made on 02/17/2023. Weekly weights were initiated on 01/31/2023. Dietary supervisor met with R2 and reviewed likes/dislikes on 03/17/2023 and the resident dietary meal slip was updated to include resident current allergy. R2 ADL for eating assistance and ADL eating care was reviewed and assistance is being provided per resident need. All existing resident who requires assistance with eating, adaptive equipment, allergies, and recent weight loss care plans and orders were reviewed and updated as needed. Future residents will be assessed upon admission and throughout the resident stay for care assistance, weights and for meal ticket creation accuracy. Nursing, therapy personnel and dietary staff were in-serviced on with Weight policy, Accommodation of Need Policy, and Food Allergy with focus on weight assessment and notification, ensuring adaptive equipment is assessed and available for use and the importance of locating resident allergies in the resident		

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F 692	Continued From page 29 glasses and drank them within the first minute. He removed the food cover over the main dish and grabbed a fork to eat the cheese and hamburger casserole. He ate the food quickly and appeared hungry. The hamburger was finely chopped up, but the cheese was not mixed in with the hamburger, but instead stuck together into one large piece. R2 was unable to break apart the large piece of melted cheese. Instead, all the cheese was lifted by his fork in one large chunk. He attempted to eat the whole piece of cheese at once. He was only able to insert a portion of the cheese causing the rest of it to hang down from his mouth. R2 tried to eat the whole piece of cheese but was unsuccessful. R2 was looking around the room and placed his left hand and a napkin in front of his mouth to hide the piece of cheese. After a few minutes he was able to remove the piece of melted cheese and placed it back on his meal tray. He tried to cut up the lemon meringue pie into smaller pieces, but was unsuccessful, so he just picked up the whole piece of pie and tried to bite into it. After a few bites, the pie fell into his lap. He did not have adaptive silverware to use and was unable to cut up his food with the fork or a knife. He struggled to pick up the hamburger casserole using a fork and to transfer the food to his mouth. No staff was in the dining room area to provide supervision and to encourage him to eat more. During observation on 2/21/23, at 8:50 a.m. R2 was sitting in his wheelchair naked, and his meal tray was on a table next to the wall. His pajama pants were on the heat register wet with urine. There was a pile of linen and a hospital gown on the bed soaked in urine. In addition, there was a pile of clean linen on the top part of the bed. R2 used a draw sheet to cover himself. His breakfast	F 692	chart and meal ticket. Director of Nursing, Dietary Manager and/or designee is responsible for compliance. Audits on residents for weight loss, meal ticket accuracy for allergies, adaptive equipment resident usage and care plan care plan items for all areas listed will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 3/27/2023		

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F 692	Continued From page 30 menu identified a mechanical soft diet, but if failed to list the shellfish allergy. Once R2 saw the meal tray he pushed himself to the table and started to eat the mechanical soft diet without issues. He picked up the salt, pepper and sugar packets but was unable to open them. R2 appeared hungry and rapidly ate his food. During interview and observation on 2/21/23, at 9:06 a.m. nursing assistant (NA)-B entered the room while R2 was eating his breakfast. She stated she started her shift on 2/21/23, at 12:00 a.m. and was working a double shift. NA-B stated R2 did not sleep well because he kept waking up to remove his pajamas throwing them on the floor. NA-B stated she entered his room around 5:00 a.m. and dropped his breakfast off at 8:00 a.m. when he was sleeping. He finished his breakfast drinking all the liquids and ate 100 % of his meal. R2's Minimum Data Set (MDS) dated 6/26/22 weight 160 lbs., 9/26/22 weight 156 lbs., 12/27/22 weight 147 lbs., 2/10/23 weight 149 lbs. R2's height is 6 ft. 0 inches. R2 had no signs of a nutritional disorder or trouble swallowing his food. After staff set up R2's meal tray and applied condiments he was then able to eat independently. R2 had an 11 lb. weight loss in eight months. R2's care plan dated 9/29/22, identified R2 had a nutritional problem due to R2's diagnosis. R2's goal was to be within 5% (7.5 lbs.) of 150 lbs. (weight on 9/26/22 was 156 lbs.) with no signs or symptoms of malnutrition consuming at least 50% of meals. Staff would "weigh per policy." In addition, staff would serve the diet ordered by the registered dietician (RD) and document the	F 692			

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F 692	Continued From page 31 amount of food he consumed after each meal. R2's hospital discharge document on 12/8/22, identified he had "severe protein calorie malnutrition", and a ten-pound (lbs.) weight loss. R2 consumed the two dietary supplements served each day. R2 was assessed for a "level 6/0 d/t dentation" diet (food prepared to a soft bite size consistency) also known as a mechanical soft (pureed, finely chopped, blended, or ground into smaller softer and easier to chew) food. In addition, R2 did not have diabetes, but was hospitalized for hypoglycemia (when a blood sugar is less than 70) and required intravenous (IV) Dextrose (a sugar supplement to raise low blood sugar levels) and constant monitoring until his levels improved. In addition, staff were required to encourage him to drink more fluids throughout the day. While R2 was hospitalized he ate 100 % of each meal to include the dietary supplements. R2 also requested snacks between mealtimes. R2's family reported to the hospital staff were concerned about his recent weight loss and thought he was not getting enough food to eat at the facility. R2's quarterly nutrition progress note dated 12/26/22, identified R1's weight loss was expected related to his Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), depression, dysphagia (difficulty swallowing), dementia, and adult failure to thrive (a multiple organ decline). No complaints of chewing or swallowing difficulties noted although diet has recently been downgraded to a mechanical soft textures and nectar (the consistency of a shake or cream-based soup)	F 692			

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F 692	Continued From page 32 thicken liquids. R2's MDS dated 12/27/22, identified R2 was able to understand conversations, but had difficulty speaking. There was no history of R2 rejecting cares from staff. R2 had malnutrition (a decrease blood protein level and calorie intake), Parkinson's disease, history of falls, dysphagia, muscle weakness, dementia, CVA (cerebral vascular accident also referred to as a stroke), anxiety, orthostatic hypotension (his blood pressure dropped when he stood up), high blood pressure and depression. R2 did not have any issues with swallowing and received a mechanically altered diet. R2 could feed himself as long as the staff set up his meal tray. R2's annual dietician assessment dated 12/27/22, at 4:07 p.m. identified he was allergic to shellfish. R2's weight fluctuation was a result of Parkinson's disease, depression, difficulty eating, dementia, and adult failure to thrive diagnoses. His diet was "recently" downgraded to a mechanical soft texture with nectar thickened liquids. R2's stated he did not feel he needed any dietary supplements. In addition, R2 was encouraged to eat all his meals and snacks. R2's dietary progress note dated 12/30/22, at 4:07 p.m. identified in the past 90 days he had a 6.1 % weight loss and in 180 days an 8.8% weight loss. R2's diet consisted of a mechanical soft texture and on average he ate 50% to 75% of his meals. He did not receive dietary supplements or adaptive equipment to help him eat. R2 was allergic to shellfish. The registered dietitian (RD)-A identified R2's Parkinson's disease, depression, dysphasia, and failure to thrive led to his weight loss.	F 692			

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F 692	Continued From page 33 R2 malnutrition screening tool dated 1/30/23 at 8:54 a.m. Identified RD attempted to discuss his recent weight loss, and suggested a dietary supplement but resident stated he was doing fine and did not want to discuss the matter right now. R2's care plan dated 1/30/23, identified a staff requirement for supervision during mealtimes to encourage him to eat more than 50% of each meal. R2's significant change progress note dated 2/10/23, identified a dietary order for a "dysphagia mechanical soft diet with nectar thick liquids, cut up textures, and thin liquid consistency (nothing is added to make the consistency thicker and easier to swallow)." R2 ate up to 50% to 70% of each meal. R2 did not have an order for dietary supplements or adaptive equipment. RD identified his diet consistency was confusing and requested speech therapy to complete a swallow study. In addition, he had a shellfish allergy. R2's swallow study dated 2/15/23, identified he needed a mechanical soft diet with regular thin liquids. In addition, the order for a liquid served at a nectar thicken consistency was a "mechanical error." During interview on 2/16/23, at 1:57 p.m. culinary supervisor (CA)-A stated the facility has an RD who comes to the facility on Wednesdays. The rest of the time she will communicate with him via emails or phone calls. She stated each resident has a pre-printed menu. On the menu would have the meals for the day, the consistency of the food, allergies and if they require adaptive equipment to eat.	F 692			

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F 692	Continued From page 34 During interview on 2/17/23, 12:26 p.m. CA-A reviewed R2's 2/17/23, food menu listing a regular/no added salt/dysphasia advanced diet was a chopped diet, not a mechanical soft diet. She confirmed there was no changes were made today to R2's diet and he would get a chopped diet again for dinner. The meal would consist of chili, shredded lettuce, crackers, cinnamon roll, and crushed pineapple. In addition, the menu did not identify R2's shellfish and he did not qualify for adaptive silverware and plate. During interview on 2/17/23, at 12:50 p.m. the registered dietitian (RD)-A stated he requested a speech therapist to conduct a swallow study and determine if R2 needed a thin or nectar thickened liquids. The speech therapist identified he was able to drink liquids safely at a thin consistency. He stated he received an email on 2/17/23, at 10:07 a.m. regarding R2's recommendation for a mechanical soft diet with regular thin liquids. He sent an email to the kitchen manager with the new diet order. He also called the DON about the new diet order, and she agreed to enter the new order it into the electronic medical record (EMR) right away. RD-A checked to see if the new diet was entered into the system and found out it was not. He stated he would call the kitchen staff directly to make sure R2 received a mechanical soft diet for his evening meal. RD-A stated he had a hard time understanding R2 and stuck with yes and no questions. RD-A stated on 1/30/23 at 7:30 a.m. he went to R2's room to discuss his weight loss and malnutrition. RD-a realized after reviewing his notes R2 did not refuse a dietary supplement but did not want to discuss his nutrition at 7:30 a.m. RD-A stated it was inappropriate for staff to throw R2's shoe at him.	F 692			

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F 692	Continued From page 35 RD-A stated he was "annoyed" to learn how the staff treated R2 and would report the inappropriate staff behavior to his cooperate supervisor adding she would not be "happy." During interview on 2/21/23, at 10:00 a.m. culinary supervisor (CA)-A stated she had no documentation reflecting R2's allergy to shellfish. She stated based on the 2/1/23, medical medication record (MAR) listing R2's allergy to "shellfish derived product" meant he should not have any fish and she would have highlighted his name on the fish allergy chart in the kitchen. CS-A stated the facility only provided one snack per day related to budget restraints. The kitchen prepared a snack tray for the evening shift and the nursing staff would pass it out to the residents. CA-A stated a while ago R2 asked her about getting a mighty shake (dietary supplement) with meals, and she notified the previous DON, but nothing came of it. During interview on 2/21/23, at 12:30 p.m. FM-A asked R2 if he was allergic to shellfish in which he said yes. R2 said he would develop hives every time he ate shellfish. He denied any allergic reactions since his admission to the facility. He was unable to clearly communicate if he picked each meal option, and if he ate any fish products during his stay at the facility. Weight Assessment and Intervention policy dated 3/1/22, identified severe weight loss of five percent in one month, 7.5 percent in three months, and 10% in six months. The facility interdisciplinary team (IDT) would discuss weight loss even if it did not meet the standard for a significant weight loss. The medical provider would work with the IDT to identify the factors	F 692			

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F 692	Continued From page 36 leading to the resident's weight loss and as a team develop care plan interventions. Diet conversions policy dated 8/31/20, identified the appropriate substitute for the 12/8/23, recommendation while he was hospitalized would have been a mechanical soft diet without bread. Not the regular, not added salt, dysphagia advanced diet he received on 2/17/23.	F 692			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 comprehensively identify pain, verify conflicting pain medication dosages, and update the medical provider when pain medication orders changed frequently identify non-pharmacological pain interventions, and for 1 of 3 residents (R2) reviewed for pain management when he had three different Tylenol dosages and the medical provider was not updated, resident stated his pain medication is not working, and staff refused to give additional pain medication after a fall. Findings include: R2's medical treatment record (MAR) dated 11/1/22, through 12/6/22, identified an order for Tylenol one 500 mg tablet (adult dosage two 500	F 697	R2 had a new pain assessment and review of current pain medications on 03/17/2023. The NP was notified, and resident pain medications were adjusted. R2 will have pain order observation for the next 30 days to ensure pain is resolved then assessed quarterly and as needed. All existing residents who receive scheduled pain medication will have their nurse pain assessment and pain score reviewed. The MD/NP will be notified if adjustments are warranted. Future residents who experience pain will be assessed upon admission, a pain assessment completed, pain medication orders reviewed for accuracy and a pain care plan initiated. Licensed nurses and nurse aides will be	3/27/23	

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F 697	Continued From page 37 milligram (mg) tablets every six hours not to exceed six pills in a 24-hour period) at 8:00 a.m. 2:00 p.m. and 8:00 p.m. R2's emergency department (ED) after visit summary dated 11/19/22, identified a Tylenol order for Tylenol take two 500 mg tablets every six hours as needed for pain. R2's care plan dated 12/6/21, identified R2 had acute pain from a shoulder injury after a fall and the pain resolved on 10/18/22. No further pain assessment or non-pharmacological pain interventions were identified. R2's hospital discharge instructions dated 12/8/22, identified an order for Tylenol one 650 mg tablet every four hours (recommended dosage two 650 mg tablets every six hours not to exceed six pills in a 24-hour period) as needed for pain. R2's MAR dated 12/9/22, through 12/31/22, identified an order for Tylenol one 500 mg tablet to be given in the morning and evening. R2's nursing progress note dated 12/26/22 at 9:25 p.m. identified R2 fell around 7:00 p.m. in the dining room injuring his head and left shoulder. Staff identified a "scrape" on the top of his left shoulder, and he complained about both of his shoulders hurting. The note identified staff gave him Tylenol for pain, when in fact R2 received a scheduled 500 mg dose on 12/26/23, during his scheduled p.m. dose. R2's Minimum Data Set (MDS) dated 12/27/22, identified R2 was able to understand conversations, but had unclear speech. R2's	F 697	in-serviced on the Pain Clinical Policy with focus on identifying resident signs and symptoms of pain and notifying the nurse of resident signs and symptoms for further assessment and MD/NP notification. Director of Nursing and/or designee is responsible for compliance. Audits on resident's pain medication, effectiveness and pain care plan will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 3/27/2023		

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F 697	Continued From page 38 assessment identified no rejection of cares. R2 had a history of falls, muscle weakness, dementia, CVA (cerebral vascular accident also known as a stroke), anxiety, and depression. R2 required limited assistance and supervision to safely move around his room and the building. R2 required an extensive assistance from one person for dressing and hygiene needs. Furthermore, R2 was not on scheduled pain medication and based on the assessment findings no further assessment was required. R2's MAR dated 1/1/23, through 1/31/23, identified an order for Tylenol one 500 mg tablet to be given in the morning and evening. R2's neurology appointment dated 1/19/23, identified his current medication list for Tylenol was to take two 500 mg tablets every six hours as needed for pain. R2's follow-up appointment dated 1/27/23, identified current outpatient medication list included Tylenol administration for one 500 mg tablet three times a day. R2's MAR dated 2/1/23, through 2/16/23, identified an order for Tylenol one 500 mg tablet to be given in the morning and the evening. R2's nurse pain tool observation dated 2/10/23, identified he denied any pain at the time of the assessment. R2's quarterly resident review dated 2/10/22, identified resident's pain intensity (0 to 10 numeric rating scale from no pain to worst pain) was a four.	F 697			

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F 697	Continued From page 39 During interview on 2/15/23, at 3:53 p.m. Department of Human Services (DHS)-A stated he visited resident R2 on 2/8/23, to conduct a survey for the Department of Human Services. When he asked R2 about the care he received from the staff he started to "profusely cry". R2 told him about a recent fall where he hurt his shoulder. R2 ask the staff for pain medication, and they told him he could not have additional Tylenol and instructed him to lay down in bed. During interview on 2/16/23, at 9:16 a.m. R2 rated his toenail pain at a 7 out of 10 (a numerical pain rating scale from zero being no pain to ten being the worst pain.) FM-A stated R2 fell at least once a week. FM-A stated he is getting weaker, and he was falling because he cannot get any help. FM-A stated the staff are not cutting R2's fingernails and toenails. He stated the poor nail care has caused R2 to suffer increased pain. FM-A stated when he visited on 2/15/23 R2 told him his toes hurt and FM-A helped remove his shoes. R2 stated the Tylenol the nurses give him was not helping to reduce his pain level. During interview on 2/16/22, at 10:00 a.m. licensed practical nurse (LPN)-A stated R2" Tylenol order for pain was one 500 mg dose two times a day. She did not know why the dosage of Tylenol was so low and she thought the nursing staff should have clarified it with the medical provider. During interview on 2/16/23 2:53 FM-A stated R2's preferred medication for pain was Tylenol and the facility only provide the bare minimum care. R2's stated he was a "grown ass man" not a child and need an adult dose of Tylenol.	F 697			

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F 697	Continued From page 40 During interview on 2/17/23, at 11:37 a.m. nursing assistant (NA)-A stated NA-A stated his toenails "look scary" and must cause pain when he wore shoes. During interview on 2/17/23, at 12:01 p.m. LPN-B stated she did not know why R2's Tylenol dosage was on one 500 mg tablet two times a day. She asked a registered nurse (RN) about the dosage and was told "that's what the doctor ordered." During interview on 2/21/23, at 1:30 p.m. the nurse practitioner (NP)-A stated the staff did not alert her about R2's complaint about pain and the different Tylenol orders placed from different providers over the last three months. She added R2 did not have a medical condition preventing him from receiving the standard adult dose of Tylenol every day. She would contact the facility today to increase his Tylenol dosage to 1000 mg three times a day. During interview on 2/21/23, at 4:30 p.m. the director of nursing (DON) stated she was not aware of the different Tylenol dosage orders in the past three months. She would have expected her nurses to clarify the different orders with the NP. In addition, she would have expected the nursing staff to report to the NP when R2 complained about increased pain after a fall and to update the medical provider for additional pain medication. Requested a pain management policy but none was provided.	F 697			
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921			3/27/23

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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 921	Continued From page 41 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: During observation, interview and document review the facility failed to provide a clean room, free from disrepair for 1 of 3 (R2) residents reviewed for home-like environment when his room had broken furniture, wall trim, urine under the bed, and uncleaned floors. During interview on 2/15/23, at 3:53 p.m. the Department of Human Services (DHS) stated he visited resident R2 on 2/8/23. When he asked R2 about the care he received from the staff he started to "profusely cry". A photo was taken by DHS-A on 2/8/23, during his interview when he observed a wash basin on the floor under his bed. R2 told him he used the basin to urinate when he was in bed. Photos of R2's room taken on 2/8/23, were of the basin under the bed full of urine, dirt, and garbage on the floor, behind R2's bed. In addition, there was a photo of the inside room door with a missing doorknob, DHS-A stated he was unable to leave the room because the door would not open. During observations throughout the day on 2/16/23 Photos of R2's bedroom were indicated: - dirt and various items on the floor, under his bed, and behind his bed. - bedroom walls indicated old, dried paint on top of the heat register, and areas on the wall below the window had paint scrapped off. - the bathroom and the bedroom door trim were loose or missing. - R2's bedroom furniture identified his night table	F 921	F 921 R2 room was thoroughly cleaned, walls repaired, bed linen changed, and furniture repaired and/or replaced. All other resident rooms were audited for room repairs. Room repairs will be prioritized for repair, linens changed, and tattered linen disposed. Rooms will be cleaned per housekeeper schedule. Future resident admissions, the resident room will be inspected prior to admission. Facility staff were in-serviced on the Homelike Environment policy with focus on ensuring that resident rooms are clean, equipment is functioning, and regular room maintenance schedule is adhered to. Director of Housekeeping/Maintenance and/or designee is responsible for compliance. Audits on resident room cleanliness, room repair will begin 2x week for 2 weeks, weekly x4 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 3/27/2023		

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F 921	Continued From page 42 provided by the facility had a missing top-drawer plate exposing the contents inside. The facility provided dresser had missing drawer handles making it difficult for R2 to open because of his medical condition. In addition, his bed frame extended outward about 12 inches from his mattress. - R2's bedroom floor identified wrappers, a pillowcase, and other items on the floor behind the bed. Various clothing items were found on the closet floor and in front of his bed. Found a blue pill and dirt on the floor below the foot of his bed. R2's saltshaker tipped over spilling on to the floor. - R2's bathroom identified dried blood on the wall tile next to the light outlet. In addition, found piles of several paper towel sheets on the floor. - R2's refrigerator a mini fridge with dried food and dirt in and outside. During interview on 2/16/23, at 12:23 p.m. the administrator walked around R2's room and bathroom. he stated his bed frame was extended outward into the bariatric (larger size bed to accommodate someone with a body mass index [BMI] greater than 35 and a history of obesity.) He stated he did not believe R2 could have injured his knees from bumping into the bed frame. Photos taken by DHS-A on 2/8/23, identified various bruises at different stages of healing on R2's lower legs and knees. The administrator denied the clutter in the room and bathroom had anything to do with R2's falls, and stated R2 only fell in the hallway or around the unit. He stated the red substance on the heat register happened when they painted the wall. He was unsure why there was three pills found in the room. He stated R2 pulled the inside doorknob off his room and refused to let the staff fix it. He stated R2 removed the night table's front plate and they had	F 921			

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F 921	Continued From page 43 replaced it three times in the past year. The administrator was unable to identify how R2 was able to pull off a doorknob or break his furniture related to his current condition and left arm and hand paralysis. A search of the room did not locate any tools or screw drivers. The administrator agreed R2's room did not meet the description of a "homelike environment", and he would not allow his mother to live in R2's room. The administrator stated it was the resident's responsibility to clean their refrigerator not the facility's staff. During interview on 2/17/23, at 10:57 a.m. R2 denied breaking the furniture and doorknob. R2 raised up his hands and said "how could I." During interview on 2/17/23, at 11:37 nursing assistant (NA)-A stated how could R2 have so much dirt and stuff on the floor and behind his bed if they are cleaning his room every day. During interview on 2/17/23 at 11:47 a.m. housekeeper (H)-A stated two housekeepers work at the facility each day. She was responsible to clean every resident room on the second floor. R2 would put his clothing and bed linen on the floor all the time. She added there is always paper toweling on the bathroom floor because he would pull all the paper toweling out every day. She did not know why he did it. She said he "does not listen" when she told him not to mess up his room. She said he changes his clothing so often they have to do his laundry every day. She added the nursing staff would place his clean clothing on a shelf in the equipment room so he would be unable to change. During interview on 2/17/23, at 1:15 p.m. the	F 921			

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F 921	Continued From page 44 head of maintenance (M)-A stated R2 is damaging his room, pulling off the trim and doorknob. He added, R2 had never refused him from doing repairs in the room. In addition, M-A stated he never saw R2 damage his room. Requested a housekeeping policy, none was provided.	F 921			

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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 2/15/23 through 2/23/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

Minnesota Department of Health		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/17/23

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H50288314C(MN90972) and H50288309C(MN90979) with a licensing order issued at 1665 and 0565. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is	2 000			

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a person-centered care plan to maintain a resident's highest practicable physical, mental, and psychosocial well-being for 1 of 1 resident (R2) reviewed for care plans. R2's lacked interventions for bladder incontinence and communication. During observation and interview on 2/16/23, at 9:00 a.m. R2 had difficulty communicating his needs and concerns. R2 had no communication tools, to make his needs known. There was no communication board in his room, and when offered a pen and paper to write down his thoughts he shook his head no. R2 had weakness, and partial paralysis on his left side making it difficult for him to write. R2 unable to	2 565	No plan	3/27/23

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2 565	Continued From page 3 answer open ended questions, could respond yes or no with a nod to verify and clarify responses. R2's care plan revised 10/19/22 indicated R2 has impaired communications, potential for communication impairment, neurological symptoms. R2's goal was to improve communication by using appropriate gestures and responding to yes or no questions. Staff interventions were to anticipate and meet R2's needs, ask yes or no questions, allow adequate time to respond repeat questions, do not rush, clarify understanding, face R2 and make eye contact, use simple brief words and/or cues, use alternative communication tools. R2's care plan did not identify alternate communication tools. R2's annual Minimum Data Set (MDS) dated 12/27/22 indicated R2 was cognitively intact and was able to understand, but his speech was unclear, slurred, and he mumbled his words. He had Parkinson's disease, dementia, malnutrition, depression, Dysphagia (impaired ability to swallow), and repeated falls. R2's MDS identified care area assessments and care planning areas for R2: urinary incontinence and/or indwelling catheter, falls, nutritional status, dental care, and pressure ulcers. R2 nor R2's family or representative participated in the comprehensive assessment and goal setting. R2's quarterly MDS dated 2/10/23 indicated R2 nor R2's family or representative participated in the comprehensive assessment and goal setting. R2's care plan initiated 1/31/23 indicated R2 was incontinent of bladder, neurogenic disorder, the goal was R2 would continent during waking hours, staff interventions were to "Check (specify freq) and as required for incontinence. Wash,	2 565		

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2 565	Continued From page 4 rinse, and dry perineum. Change clothing PRN after incontinence episodes." R2's care planned interventions to keep R2 continent were not person centered as R2 urinated in containers in his room and his clothing was often wet. During interview on 2/15/23, at 3:53 p.m. Department of Human Services (DHS)-A stated he visited resident R2 on 2/8/23, to conduct a survey for the Department of Human Services. When he asked R2 about the care he received from the staff he started to "profusely cry." A photo was taken by DHS-A on 2/8/23, during his interview when he observed a wash basin on the floor under his bed. R2 told him he used the basin to urinate in when he was in bed. Additional photos included pictures of his room in disrepair, dirty living space, piles of dirt and various of items under his bed, and up against the wall. During interview on 2/16/23, at 9:16 with R2's family member (FM)-A stated he had a hard time understanding his brother. He stated R2 was unable to physically write down his thoughts on paper. He stated R2 did receive speech therapy when he first arrived at the facility, but he no longer qualified for further treatment. He stated R2 was never presented with a communication board (a list of symbols or pictures to help identify needs when unable to speak clearly.) During interview on 2/17/23, at 10:57 a.m. physical therapist (PT)-A stated R2 was assessed by a speech therapist and reminded him to speak clearly, and slowly. She stated the staff who work with him can understand his needs. She added the facility had communication boards but did not present one to R2 because they wanted him to practice his speech. In addition, she did not know if he would even use it to communicate his needs.	2 565			

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2 565	Continued From page 5 During interview on 2/17/23, at 11:37 a.m. nursing assistant (NA)-A said she struggled to understand R2 and was unable to think of any strategies or communication tools to help him communicate his needs. During interview on 2/17/23, at 12:50 p.m. RD-A stated he had a hard time understanding R2 and he would limit the conversation to yes or no questions. During interview on 2/21/23, at 3:58 p.m. nursing assistant (NA)-D stated she had a hard time understanding R2. She was trained to ask him yes and no questions and reminded him to speak slowly. She confirmed R2 did not have a communication board in his room. During interview on 2/21/23, at 4:30 p.m. the director of nursing (DON) stated staff were able to understand R2 if they reminded him to slow down. She did not feel at this point R2 needed a communication board to promote communication. The facility policy titled Care Plans, Comprehensive Person-Centred undated version 1.3 indicated each resident ' s comprehensive person-centered care plan will be consistent with the resident ' s rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; b. identify individuals or roles to be included; c. request meetings; d. request revisions to the plan of care; e. participate in establishing the expected goals and outcomes of care; f. participate in determining the type, amount, frequency and duration of care;	2 565			

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2 565	Continued From page 6 g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made. 7. The care planning process will: a. facilitate resident and/or representative involvement; b. include an assessment of the resident ' s strengths and needs; and c. incorporate the resident ' s personal and cultural preferences in developing the goals of care. 8. The comprehensive, person-centered care plan will: a. include measurable objectives and timeframes; b. describe the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being; c. describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; d. describe any specialized services to be provided as a result of PASARR recommendations; e. include the resident ' s stated goals upon admission and desired outcomes; f. include the resident ' s stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. incorporate identified problem areas; h. incorporate risk factors associated with identified problems; i. build on the resident ' s strengths; j. reflect the resident ' s expressed wishes regarding care and treatment goals; k. reflect treatment goals, timetables and	2 565		

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2 565	Continued From page 7 objectives in measurable outcomes; l. identify the professional services that are responsible for each element of care; m. aid in preventing or reducing decline in the resident ' s functional status and/or functional levels; n. enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. reflect currently recognized standards of practice for problem areas and conditions. 9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a. No single discipline can manage an approach in isolation. b. The resident ' s physician (or primary healthcare provider) is integral to this process. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident. 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change. 14. The interdisciplinary team must review and update the care plan:	2 565		

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2 565	Continued From page 8 a. when there has been a significant change in the resident ' s condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. continues on next page SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 565		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: During observation, interview and document review the facility failed to provide a clean room, free from disrepair for 1 of 3 (R2) residents reviewed for home-like environment when his room had broken furniture, wall trim, urine under the bed, and uncleaned floors. During interview on 2/15/23, at 3:53 p.m. the Department of Human Services (DHS) stated he visited resident R2 on 2/8/23. When he asked R2	21665	No plan	3/27/23

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21665	Continued From page 9 about the care he received from the staff he started to "profusely cry". A photo was taken by DHS-A on 2/8/23, during his interview when he observed a wash basin on the floor under his bed. R2 told him he used the basin to urinate when he was in bed. Photos of R2's room taken on 2/8/23, were of the basin under the bed full of urine, dirt, and garbage on the floor, behind R2's bed. In addition, there was a photo of the inside room door with a missing doorknob, DHS-A stated he was unable to leave the room because the door would not open. During observations throughout the day on 2/16/23 Photos of R2's bedroom were indicated: - dirt and various items on the floor, under his bed, and behind his bed. - bedroom walls indicated old, dried paint on top of the heat register, and areas on the wall below the window had paint scrapped off. - the bathroom and the bedroom door trim were loose or missing. - R2's bedroom furniture identified his night table provided by the facility had a missing top-drawer plate exposing the contents inside. The facility provided dresser had missing drawer handles making it difficult for R2 to open because of his medical condition. In addition, his bed frame extended outward about 12 inches from his mattress. - R2's bedroom floor identified wrappers, a pillowcase, and other items on the floor behind the bed. Various clothing items were found on the closet floor and in front of his bed. Found a blue pill and dirt on the floor below the foot of his bed. R2's saltshaker tipped over spilling on to the floor. - R2's bathroom identified dried blood on the wall tile next to the light outlet. In addition, found piles of several paper towel sheets on the floor. - R2's refrigerator a mini fridge with dried food	21665			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/23/2023
NAME OF PROVIDER OR SUPPLIER HIGHLAND OPERATIONS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2319 WEST SEVENTH STREET SAINT PAUL, MN 55116		
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21665	Continued From page 10 and dirt in and outside. During interview on 2/16/23, at 12:23 p.m. the administrator walked around R2's room and bathroom. he stated his bed frame was extended outward into the bariatric (larger size bed to accommodate someone with a body mass index [BMI] greater than 35 and a history of obesity.) He stated he did not believe R2 could have injured his knees from bumping into the bed frame. Photos taken by DHS-A on 2/8/23, identified various bruises at different stages of healing on R2's lower legs and knees. The administrator denied the clutter in the room and bathroom had anything to do with R2's falls, and stated R2 only fell in the hallway or around the unit. He stated the red substance on the heat register happened when they painted the wall. He was unsure why there was three pills found in the room. He stated R2 pulled the inside doorknob off his room and refused to let the staff fix it. He stated R2 removed the night table's front plate and they had replaced it three times in the past year. The administrator was unable to identify how R2 was able to pull off a doorknob or break his furniture related to his current condition and left arm and hand paralysis. A search of the room did not locate any tools or screw drivers. The administrator agreed R2's room did not meet the description of a "homelike environment", and he would not allow his mother to live in R2's room. The administrator stated it was the resident's responsibility to clean their refrigerator not the facility's staff. During interview on 2/17/23, at 10:57 a.m. R2 denied breaking the furniture and doorknob. R2 raised up his hands and said "how could I." During interview on 2/17/23, at 11:37 nursing	21665		

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21665	Continued From page 11 assistant (NA)-A stated how could R2 have so much dirt and stuff on the floor and behind his bed if they are cleaning his room every day. During interview on 2/17/23 at 11:47 a.m. housekeeper (H)-A stated two housekeepers work at the facility each day. She was responsible to clean every resident room on the second floor. R2 would put his clothing and bed linen on the floor all the time. She added there is always paper toweling on the bathroom floor because he would pull all the paper toweling out every day. She did not know why he did it. She said he "does not listen" when she told him not to mess up his room. She said he changes his clothing so often they have to do his laundry every day. She added the nursing staff would place his clean clothing on a shelf in the equipment room so he would be unable to change. During interview on 2/17/23, at 1:15 p.m. the head of maintenance (M)-A stated R2 is damaging his room, pulling off the trim and doorknob. He added, R2 had never refused him from doing repairs in the room. In addition, M-A stated he never saw R2 damage his room. Requested a housekeeping policy, none was provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21665		