DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 12, 2022

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: July 7, 2022

Dear Administrator:

On July 19, 2022, we informed you of imposed enforcement remedies.

On September 29, 2022, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

F0607 -- S/S: D -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies
F0684 -- S/S: D -- 483.25 -- Quality Of Care
F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
F0756 -- S/S: D -- 483.45(c)(1)(2)(4)(5) -- Drug Regimen Review, Report Irregular, Act On
20900 -- MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers
21530 -- MN Rule 4658.1310 A.B.C -- Drug Regimen Review

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 23, 2022, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 23, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 23, 2022.

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

As we notified you in our letter of July 19, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 23, 2022. However, due to the extended survey the new NATCEP loss date is August 9, 2022.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

to:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 7, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

formal notification of that determination.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 2022

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: July 7, 2022

Dear Administrator:

On October 29, 2022, we notified you a remedy was imposed. On November 16, 2022 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 16, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 23, 2022 be discontinued as of November 16, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 19, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 9, 2022.

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

An equal opportunity employer.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

November 23, 2022

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: Project Number 37FY13

Dear Administrator:

On November 14, 2022, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $650.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on November 16, 2022 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $1,300.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $359.60, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $1,659.60 within 15 days of the receipt of this notice. That check should be forwarded to:

Department of Health
Health Regulation Division,
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

Sincerely



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

cc: Shellae Dietrich, Program Assurance Superviosr
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 24, 2022

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: CCN: 245289
Cycle Start Date: July 7, 2022

Dear Administrator:

On August 8, 2022, we informed you of imposed enforcement remedies.

On August 9, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On August 5, 2022, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of E.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 23, 2022, will remain in effect.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 23, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 23, 2022.

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

As we notified you in our letter of July 19, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide

Training and/or Competency Evaluation Programs (NATCEP) for two years from August 23, 2022. However, due to the extended survey the new NATCEP loss date is August 9, 2022.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Terrace At Crystal Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 9, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 7, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that

termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 24, 2022

Administrator
The Terrace At Crystal LLC
3245 Vera Cruz Avenue North
Crystal, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: 37FY11

Dear Administrator:

The above facility was surveyed on August 1, 2022 through August 9, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	C 08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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 8/1/22 through 8/9/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F600, when R1 was observed to bite R5 and facility failed to implement interventionts to protect other residents from R1's behaviors, which lead to additional resident to resident physical altercations. The IJ began on 7/11/22, and the immediacy was removed on 8/5/22. The above findings constituted substandard quality of care, and an extended survey was conducted on 8/8/22. The following complaints were found to be SUBSTANTIATED: H52893729C (MN85651, MN85680, MN85664), with defiencies cited at F686 and F684. H52893242C (MN85016). and H52893549C (MN85410), with deficiency cited at F600. The following complaints were found to be UNSUBSTANTIATED: H52893516C (MN85419), H52893658C (MN85560). As a result of the investigation, additional deficiencies were cited at F607, F609, F744 and F756. The facility's plan of correction (POC) will serve	F 000		

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

Electronically Signed | 09/01/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	C 08/09/2022

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THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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F 000	Continued From page 1 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 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to protect 4 of 4 (R2, R5, R9, R10) residents from resident-to-resident abuse when R1 physically abused them. In addition, the facility failed to implement immediate	F 600	F600 1. Immediate action(s) taken for the identified problem include: All staff were educated on the importance of keeping residents safe, along with	9/3/22

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F 600	Continued From page 2 and ongoing interventions to keep residents safe from further abuse which resulted in an immediate jeopardy (IJ) situation for (R2, R5, R9, R10) and potential for harm, injury, impairment, or death to all 19 residents currently residing on the 2nd floor memory care unit. The immediate jeopardy began on 7/11/22, when R1 was observed to bite R5 and facility failed to implement interventions to protect other residents from R1's behaviors, which lead to additional resident to resident physical altercations, and was identified on 8/3/22. The administrator, director of nursing, social service assistant, dietary director, and business office manager were notified of the IJ at 6:38 p.m. on 8/3/22. The immediate jeopardy was removed on 8/5/22, but noncompliance remained at the lower scope and severity level 2 scope and severity level of an E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's annual Minimal Data Set (MDS) dated 6/6/22, indicated R1 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R1 did not exhibit physical behaviors. R1's care plan dated 12/14/19, indicated R1 had a history of being physically aggressive by hitting other residents. R1's care plan lacked evidence of interventions for safeguarding vulnerable residents living with/near vicinity of R1.	F 600	keeping residents separated during an altercation. The identified residents' care plans have been reviewed and updated and interventions communicated to nursing staff. 2. Identification of similar occurrences of the problem was accomplished by: All residents have the potential to be affected by this type of situation. All care plans and interventions have been reviewed, updated and communicated to nursing staff as appropriate. 3. Actions taken/systemic changes put into place to ensure deficient practice will not recur: All staff will be educated on the policy for abuse and neglect and the importance of keeping residents separated during an altercation. Nursing staff have been educated on the necessity of following the individuals care plan and the IDT will update said care plans as needed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: All staff will receive ongoing education regarding the abuse policy and appropriate response to abuse. Social services will audit behavior progress notes and or risk management and report changes in behaviors at IDT meetings. Any issues found will be brought to QAPI. Corrective action completion date: 9/3/2022	

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F 600	Continued From page 3 R2's quarterly MDS dated 7/6/22, indicated R2 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R2 did not exhibit behaviors. R9's quarterly MDS dated 7/26/22, indicated R9 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R9 exhibited delusional behavior. R10's quarterly MDS dated 5/13/22, indicated R10 had a diagnosis of dementia and had cognitive impairments. Further review of MDS, indicated R10 did not exhibit behaviors. Review of facility report to the State Agency (SA) dated 7/11/22, indicated R1 was observed to have R5's thumb in her mouth (biting). Review of facility's 5-day investigation lacked evidence of actions implemented to protect other residents from R1's physical behaviors. Review of facility report to the SA dated 7/23/22, R1 was observed making threats towards R2 punched R2 on the arm. At the time of the incident, R1 and R2 shared the same room. Review of facility's 5-day investigation lacked evidence of actions implemented to protect R2 from further abuse as well as other residents from R1's physical behaviors. On 8/1/22, at 3:00 p.m. R1 and R2 were observed in their shared room with the door	F 600		

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F 600	Continued From page 4 closed. On 8/3/22, during continuous observation starting at 1:27 p.m. surveyor heard screaming coming from the day room (open common area that include nursing station/hallway threshold /day room). Surveyor observed R1 continuing to yell out in the day room while additional staff removed R9 from the day room while she made comments such as, "she grabbed my arm" and "she hit me hard" referring to R1. R1 remained in the day room with other residents. At 1:40 p.m. R1 was observed still upset and yelling in the dayroom while speaking with social services (SS)-A. SS-A was observed to leave R1 in the day room as R1 continued to be upset. R1 was then observed to self-propel in her wheelchair to R10 who was sitting in his wheelchair in the day room and kicked his shin. Trained medication aide (TMA)-B and registered nurse (RN)-A intervened and separated R1 and R10. Staff removed R10 from the day room, however, R1 remained in the day room area with other residents. R1 moved near nursing station area. Surveyor was in the commons area by nursing station with R1, no other facility staff were in the area. R1 was observed to be making threatening gestures towards another resident in the area and sticking her tongue out. At 1:56 p.m. R1 continued to be upset and making threatening gestures to another resident in area and began to self-propel in her wheelchair to resident while staff was at the nursing cart and staff was able to intervene. On 8/3/22, 2:35 p.m. R1 was observed in the commons area with other residents and the nursing station was unsupervised.	F 600		

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F 600	Continued From page 5 On 8/2/22, 10:26 a.m. nursing assist (NA)-A indicated R1 was physical with staff and residents "a lot" and interventions were to reapproach and while in the commons area with other residents staff are to "watch" and a staff member was expected to sit in the room while R1 was in the commons area. On 8/2/22, at 11:36 a.m. NA-B stated she was assisting R1 and R2 with morning cares when R1 became aggressive and beat R2 on her arm, wrist and leg. R2 then got upset and hit R1 on her arm and legs. Further, NA-B stated she was not sure what intervention was implemented following the incident as "it is not my job to decide what to do". On 8/2/22, at 12:02 p.m. TMA-A stated R1 had an "explosive temper" and "you can't come close to her, or she will hurt you." On 8/2/22, at 4:53 p.m. social services (SS)-A stated R1 had physical behaviors and "can't be near most residents". Further SS stated staff were expected to separate R1 from other residents by 3-4 feet when agitated to give her some space. SS confirmed there were no additional intervention implemented following R1's incidents with R2 and R5. On 8/3/22, at approximately 1:30 p.m. TMA-B stated R9 was attempting to sit behind R1 in the recliner when her walker bumped into R1 which	F 600		

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F 600	Continued From page 6 caused R1 to hit R9 on her arm. On 8/3/22, at approximately 1:35 p.m. health unit coordinator (HUC)-B confirmed she witnessed R1 "slap" R9 on her arm. On 8/3/22, at 2:12 p.m. NA-E indicated she was not aware of R1's history of aggressive behaviors towards other residents. On 8/3/22, at 2:34 p.m. R9 was laying in her bed and immediately became tearful and stated, "I didn't do anything, I was going to sit in the chair, and she started pounding on me. I am scared of her; she should be in a different area. I guess I will just stay in my room and go out for meals and not go out there by her." On 8/3/22, at 3:25 p.m. TMA-B indicated she was not aware of R1 having a history of being physically aggressive with other residents. When asked how staff protect other residents when R1 is upset, TMA-B stated she had never been in a situation where she felt she needed to protect other residents from R1. On 8/3/22 at 4:35 p.m. interview with nurse manager and director of nursing (DON) stated SS was in charge of the investigation and implementing interventions following the determination of a root cause. DON stated staff were expected to keep residents safe and separate residents following an altercation, so another incident does not occur. DON confirmed	F 600		

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F 600	Continued From page 7 R1's care plan had not been updated with interventions for physical behaviors since 2019 and the care guide sheet as of 8/3/22, had no safety interventions for R1's behaviors. Review of facility policy titled Reporting Abuse to Facility Management, not dated, indicated the facility does not condone resident abuse by anyone including other residents. Review of facility policy titled Abuse Investigation and Reporting dated 12/6/21, directed staff to protect residents during abuse investigations. Further review of abuse policy lacked evidence of clear guidance on how staff will immediately protect residents following a resident to resident altercation and implementing appropriate interventions following an altercation. The immediate jeopardy that began on 7/11/22, was removed on 8/5/22 at 1:55 p.m., when the facility updated R1's care plan to include behavioral interventions such as encouraging R1 to engage in appropriate activities, prevent over crowding or close enough to touch others, R1 was moved to a private room, and assigned nursing assistant to transport R1 to and from dining area or lounge and R1 to remain within eye sight of staff. In addition, staff's care guides were updated to reflect R1's interventions, staff were educated on updated interventions as well as abuse and reporting, but noncompliance remained at a lower scope and severity level of an E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 600		

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F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse policy related to reporting incidents of resident-to-resident abuse for 2 of 4 residents (R9, R10) who were reviewed for abuse. In addition, the facility failed to develop clear guidelines for protection of the resident during completion of a thorough investigation. Findings include: R1's annual minimal data set (MDS) dated 6/6/22, indicated R1 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R1 did not exhibit physical behaviors. R9's quarterly MDS dated 7/26/22, indicated R9 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R9 exhibited delusional behavior. R10's quarterly MDS dated 5/13/22, indicated	F 607	F607 1. Immediate action(s) taken for the identified problem include: IDT met to discuss the abuse/neglect policy requirements and developed a policy that meets regulatory requirements. 2. Identification of similar occurrences of the problem was accomplished by: All residents have the potential to be affected by this type of situation. 3. Actions taken/systemic changes put into place to ensure deficient practice will not recur: All policies will be reviewed to ensure regulatory requirements are met. Employees will receive training on revised polices for implementation of change. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The administrator and/or designee will make appropriate changes. Any issues found will be brought to QAPI.	9/3/22

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F 607	Continued From page 9 R10 had a diagnosis of dementia and had cognitive impairments. Further review of MDS, indicated R10 did not exhibit behaviors. On 8/3/22, at 1:27 p.m. surveyor heard screaming coming from the day room. Surveyor observed R1 continuing to yell out in the day room while additional staff removed R6 from the day room. R6 was observed making comments such as "she grabbed my arm" and "She hit me hard" referring to R1. On 8/3/22, at approximately 1:30 p.m. interview with trained medication assistance (TMA)-B stated R9 was attempting to sit behind R1 in the recliner when her walker bumped into R1 which caused R1 to hit R9 on her arm. On 8/3/22, at approximately 1:30 p.m. health unit coordinator (HUC)-B confirmed she witnessed R1 "slap" R9 on her arm. On 8/3/22, at 1:40 p.m. R1 was observed upset and yelling in the dayroom while speaking with social services (SS)-A. SS-A was observed leaving R1 in the day room as R1 continued to be upset. R1 was then observed to self-propel in her wheelchair to R10 who was sitting in his wheelchair in the day room and kicked his shin. TMA-B and registered nurse (RN)-A intervened and separated R1 and R10. On 8/3/22, at 3:25 p.m. TMA-B stated staff were expected to report all resident to resident altercations to the charge nurse immediately. TMA-B confirmed she report both incidents involving R1 with R9 and R10 to the charge nurse RN-A, however was unsure if RN-A reported them to administrator.	F 607	Corrective action completion date: 9/3/2022	

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F 607	Continued From page 10 On 8/1/22, at 12:36 p.m. during entrance conference with social services (SS)-A surveyor requested the facility's abuse policy which surveyor was provided a three page policy. On 8/2/22, at 9:50 a.m. surveyor inquired about additional parts to the abuse policy to the director of nursing (DON) who provided 5 additional pages to the abuse policy. Review of facility policy titled Abuse Investigation and Reporting dated 12/6/21, indicated all alleged violations involving abuse will be reported immediately but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury. In addition, facility policy indicates staff would "protect residents during abuse investigations" however the policy lacked clear guidance on the facility procedure for protection of residents. Facility policy did include upon receiving reports of physical or sexual abuse a licensed nurse or physician shall immediately examine the resident. The policy lacked the following requirements for protection: increased supervision of the alleged victim and residents, room or staffing changes if necessary to protect the residents from the alleged perpetrator, protection from retaliation and providing emotional support and counseling to the resident during the investigation. On 8/3/22, at 4:35 p.m. interview with both licensed practical nurse (LPN)-B and DON indicated staff were expected to report resident to resident altercations to the DON and SS-A upon ensuring safety of all residents involved in the incident. DON confirmed she was not aware of	F 607		

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F 607	Continued From page 11 the two incidents involving R1 with R9 and R10 on 8/3/22. On 8/4/22, at 2:05 p.m. SS-A indicated abuse investigations had been assigned to social services to complete. Further, SS-A indicated she was not trained on how to complete an investigation and was not aware of what the facility's policy was on protecting residents during an abuse investigation. On 8/4/22, at 3:05 p.m. administrator the facility's policy directed staff to report incidents of abuse to the administrator or management within two hours. Administrator confirmed he was not aware of the two incidents involving R1, R9 and R10 until surveyor notified DON on 8/3/22. In addition, when asked what the facility's policy was regarding providing protection to the residents during an abuse investigation, Administrator stated, "policy on protection is broad in the policy due to every incident is different you tailor the abuse protection to the person's needs" and following an incident the interdisciplinary team (IDT) meets and will determine a plan that was "tailored towards the incident". Further, administrator indicated the facility's policy are created by corporate who review the regulations and then the policy would be reviewed by the IDT at the facility when an incident occurs, or the facility needs clarification the facility would use the policy for guidance. Administrator confirmed the copy of the facility's abuse policy provided to the surveyor was the current policy, but Administrator wanted to check the system to ensure all parts of the policy were given. Surveyor did not receive anymore additional documents related to the facility's abuse policy.	F 607		

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F 609	Continued From page 12	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review, the facility failed to report resident to resident physical abuse allegations timely to the Administrator of the facility and State Agency (SA) per regulation, within two hours, for 2 of 4 residents (R9, R10), who were reviewed for	F 609	F609 1. Immediate action(s) taken for the identified problem include: Staff have been educated on the importance of reporting incidents in the required timeline.	9/3/22

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F 609	Continued From page 13 abuse from R1. Findings include: R1's annual minimal data set (MDS) dated 6/6/22, indicated R1 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R1 did not exhibit physical behaviors. R9's quarterly MDS dated 7/26/22, indicated R9 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R9 exhibited delusional behavior. R10's quarterly MDS dated 5/13/22, indicated R10 had a diagnosis of dementia and had cognitive impairments. Further review of MDS, indicated R10 did not exhibit behaviors. On 8/3/22, at 1:27 p.m. surveyor heard screaming coming from the day room. Surveyor observed R1 continuing to yell out in the day room while additional staff removed R6 from the day room. R6 was observed making comments such as "she grabbed my arm" and "She hit me hard" referring to R1. On 8/3/22, at approximately 1:30 p.m. interview with trained medication assistance (TMA)-B stated R9 was attempting to sit behind R1 in the recliner when her walker bumped into R1 which caused R1 to hit R9 on her arm. On 8/3/22, at approximately 1:30 p.m. health unit coordinator (HUC)-B confirmed she witnessed R1 "slap" R9 on her arm. On 8/3/22, at 1:40 p.m. R1 was observed upset	F 609	2. Identification of similar occurrences of the problem was accomplished by: All residents have the potential to be affected by this type of situation. 3. Actions taken/systemic changes put into place to ensure deficient practice will not recur: All IDT will be re-trained and have access to the OHFC process to be able to submit an incident. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The administrator and/or designee will be informed immediately when an incident has been identified to ensure the incident is reported in a timely manner. Behavior and or OFHC meetings will be conducted weekly for 2 months or until substantial compliance is met. Corrective action completion date: 9/3/2022	

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F 609	Continued From page 14 and yelling in the dayroom while speaking with social services (SS)-A. SS-A was observed leaving R1 in the day room as R1 continued to be upset. R1 was then observed to self-propel in her wheelchair to R10 who was sitting in his wheelchair in the day room and kicked his shin. TMA-B and registered nurse (RN)-A intervened and separated R1 and R10. On 8/3/22, at 3:25 p.m. TMA-B stated staff were expected to report all resident to resident altercations to the charge nurse immediately. TMA-B confirmed she report both incidents involving R1 with R9 and R10 to the charge nurse RN-A, however was unsure if RN-A reported them to administrator. On 8/3/22, at 4:35 p.m. interview with both licensed practical nurse (LPN)-B and director of nursing (DON) indicated staff were expected to report resident to resident altercations to the DON and SS-A upon ensuring safety of all residents involved in the incident. DON confirmed she was not aware of the two incidents involving R1 with R9 and R10 on 8/3/22. On 8/4/22, at 3:05 p.m. administrator the facility's policy directed staff to report incidents of abuse to the administrator or management within two hours. Administrator confirmed he was not aware of the two incidents involving R1, R9 and R10 until surveyor notified DON on 8/3/22. Based on record review no report was made to the SA within two hours or at time of exit. Review of facility policy titled Abuse Investigation and Reporting dated 12/6/21, indicated all alleged violations involving abuse will be reported	F 609		

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F 609	Continued From page 15 immediately but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury.	F 609		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents identified at risk for worsening skin wounds received the necessary care and treatment to prevent the development of maggots in a wound for 1 or 1 residents (R6) who was hospitalized for a wound infestation. This resulted in harm for R6. Findings include: R6 was observed on 8/1/22, visiting with the nurses at the nurses station. A bandage on her left lower leg presented with signs of weeping yellow tinge coming through the bandage. A Facility Reported Incident (FRI) submitted to the Stage Agency (SA) on 8/1/22, at 9:59 p.m. identified licensed staff who worked the 8/1/22 evening shift removed R6's dressing per her treatment orders and observed "multiple maggots in wound bed secondary to date on dressing	F 684	F684 1. Immediate action(s) taken for the identified problem include: Clinical Staff were educated on following wound care orders and the policy on changing and dating wound dressings. 2. Identification of similar occurrences of the problem was accomplished by: R6 care plans were reviewed and updated and all residents with wounds orders will be reviewed and assessed. All residents have the potential to be affected by this type of situation. 3. Actions taken/systemic changes put into place to ensure deficient practice will not recur: Nursing staff to be re-educated on wound care protocols. DON and/or designee will review all residents at risk for pressure ulcers and/or non-pressure related skin impairments to assure they are receiving	9/3/22

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F 684	Continued From page 16 being approximately 3 (three) days old." R6's Emergency Department Staff Physician Note dated 8/2/22, at 12:49 a.m. identified on exam R6's left lower extremity (LLE) showed evidence of necrotic appearing tissue and lacked larva/maggots on exam. The note indicated R6's family showed the provider a video with what appeared to be larva present particularly on the LLE. Due to R6's initial diagnosis of LLE wound and "maggot infestation," R6 was admitted for intravenous (IV) antibiotics and wound care. R6's Hospitalist Progress Note dated 8/4/22, identified IV antibiotics were stopped as infectious disease (ID) on 8/4/22, felt R6's LLE wounds were not infected. A wound care consult was ordered. Wound care consult notes were requested: none were provided. R6's quarterly Minimum Data Set (MDS) dated 5/24/22, identified R6's cognitive status was not tested; however, the MDS identified R6 was independent with mobility and daily cares. Diagnosis included cancer, dementia and mild cognitive impairment, diabetes insipidus (imbalance of water in the body), morbid obesity, anemia, and lymphedema (condition with swelling of legs or arms). In addition, the MDS identified R6 was free of ulcers, wounds, or skin problems; however, staff applied an ointment/medication to R6. R6's Care Plan printed 8/9/22, identified R6 resisted treatments to her legs related to (r/t) confusion and provided examples of non-compliance: leg elevation, decreased fluid intake, and leg treatments. Interventions were identified as educating R6 of the possible	F 684	the necessary treatment/services to prevent skin impairments from developing and to promote healing. Wound supplies available will reflect the di 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Wound round progress notes to be audited by DON and/or designee to monitor for accuracy. The DON and/or designee will conduct measurable audits twice a week for 4 weeks or until substantial compliance is met of the delivery of care to residents affected to ensure appropriate care and services are implemented and reduce the risk for skin impairments. Any issues will be reported immediately for correction, and to QAPI. Corrective action completion date: 9/3/2022	

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F 684	Continued From page 17 outcome(s) of not complying with treatment or cares, encouraging her to participate as much as possible during cares, and giving clear explanation of all care activities prior to and as they occur during each contact. Further, R6's Care Plan identified on 6/7/22, R6 had an open area to her lower extremities related to increased edema and "scratching the fragile skin." R6's goals were to be free from open lesions or injuries to her lower extremities, she would be free of complications to the open lesions, the open lesions would remain stable, and she would maintain or develop clean and intact skin by the review date. Interventions were to avoid scratching, educate her of causative factors and measures to prevent skin injury, encourage good nutrition and hydration to promote healthier skin, identify/document potential causative factors and eliminate/resolve where possible, keep skin clean and dry, use lotion to skin, report abnormalities to the provider, assistance to apply wraps ordered by physical therapy (PT) to bilateral extremities, and weekly treatment documentation. R6's Care Plan lacked evidence of individualized interventions which directed staff on actions, outside of verbal education and reminders, to attempt when R6 resisted wound care active and preventative treatments. Vohra Wound Physicians Initial Wound Evaluation and Management Summary, dated 6/7/22, identified R6 was examined to have one "lymphademic" wound (full thickness) to her right leg (1 cm (centimeter - length) x 1.4cm (width); 1.40cm surface area (length x width); 100 percent (%) granulation (sign of healing) tissue) and one to her left leg (2.8cm x 1.3cm; 90% slough (dead skin tissue). Initial provider orders were as follows:	F 684		

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F 684	Continued From page 18 -Xeroform sterile gauze covered by a Kerlix dressing (to both legs) QD (every day). R6's TARs (treatment administration record(s) dated 6/7/22 - 8/1/22, directed staff to cleanse the back of R6's left leg and apply a dry dressing BID (twice a day) before ace wraps were applied; however the MARs/TARs lacked the QD Xeroform/Kerlix order to both legs and lacked evidence of any directed wound care order to R6's right leg. -Recommendation was provided to elevate leg(s). R6's MARs/TARs dated 6/7/22 - 8/1/22 directed staff to encourage R6 to elevate her legs while lying in bed and lacked directions for leg elevation at other times. Subsequent Vohra visits identified the following information (wound care orders and recommended leg elevation remained unchanged from the 6/7/22 order unless indicated): -6/14/22: Right leg wound progress deteriorated (2cm x 6cm; 12cm surface area; 80% slough, and 20% granulation tissue) and the left leg improved. -6/24/22: Right leg wound progress improved and the left leg remained unchanged. An order was provided for PT (physical therapy) to evaluate for multilayer compression wraps for lymphedema. R6's medical record lacked evidence of the PT order or that PT was updated to the order. -7/5/22: Right leg wound progress showed the wound resolved. The left leg (1cm x 0.5cm; 0.50cm surface area; 5% slough; 95% granulation) wound progress improved. -7/12/22: Left leg wound progress deteriorated (18cm x 36cm; 648cm surface area; 5% slough; 95% granulation). In response, Aquaphor was ordered to be applied QD to the periwound (outside edges of the wound). In addition, the	F 684		

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F 684	Continued From page 19 dictation indicated an initial evaluation of a full thickness lymphademic wound of R6's right leg was completed (9cm x 8cm; 72cm surface area, 100% granulation tissue) with an associated procedure note: "This wound has previously undergone autolytic debridement." In response, Xeroform sterile gauze covered by a Kerlix dressing and Aquaphor applied periwound QD was ordered. R6's TARs dated 7/12/22 - 8/1/22, directed staff to apply Aquaphor ointment to R6's lower leg/extremities BID and PRN (as needed); however, the TARs lacked evidence of the 7/12/22 Aquaphor directed left leg periwound order. In addition, the MARs/TARs dated 7/12/22-8/1/22, lacked evidence staff were directed to provide, or provided, the Xeroform/Kerlix order to R6's right leg wound. -7/19/22: Left leg (4.6cm x 1cm; 4.6cm surface area; 5% slough) and right leg (1.6cm x 0.7cm; 1.12cm surface area; 100% granulation) wound progresses improved. -7/26/22: Left leg (12cm x 5cm; 60cm surface area; 90% slough; 10% granulation) and right leg (1.4cm x 1.6cm; 2.24 cm surface area; 100% granulation) wound progresses deteriorated. In response, Santyl (enzymatic debridement agent) was ordered QD to be applied to both wounds. R6's MARs/TARs dated 7/26/22 - 8/1/22, lacked evidence staff were directed to apply, or applied, Santyl to R6's bilateral leg wounds. R6's 6/1/22 - 8/1/22 MARs/TARs, identified the following additional skin/wound care treatments: -TAR: Ace wraps on every morning and removed at bedtime for edema (fluid in the legs), in which they were to be applied at 8:00 a.m. -TAR: Lymphedema wraps to lower extremities QD which were directed to be applied at 8:00 a.m.	F 684		

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F 684	Continued From page 20 -TAR: If R6 refused lymphedema wraps, start TED (compression socks decrease blood clots) stockings instead every shift. R6's Skin and Wound Evaluation V5 dated 6/7/22, identified R6 had a new open lesion. The location box remained blank. The evaluation identified R6 experienced increased edema to her lower extremities which caused her to scratch at the area causing it to open. PT worked with R6 to control the fluid build-up. Nursing initiated an order to apply Aquiform to the area twice daily (BID) to help minimize the itching. In addition, staff encouraged R6's compliance with set up treatments and lower extremity wraps, to sleep in her bed and to not scratch at her legs (right leg font skin area). R6's Skin and Wound Evaluation V5.0 dated 7/12/22, identified R6 had a new open lesion. The location box remained blank. The evaluation identified R6's wound was slow to heal as R6 kept removing the dressing to scratch at the area. The wound dressing order remained the same. In addition, R6 was educated on the importance of keeping the dressing intact and to avoid scratching the wounds. R6's Skin and Wound Evaluation V5.0 dated 7/19/22, identified R6 had a new left shin open lesion. The evaluation identified R6's wound status was stable; however, the wound was at risk for deteriorating as R6 continuously scratched and removed the dressing. The wound dressing order remained the same. In addition, R6 was educated to not scratch the wound and not to remove the wound dressing. R6's Skin and Wound Evaluation V5.0 dated	F 684		

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F 684	Continued From page 21 7/26/22, identified R6 had a new left shin open lesion. The evaluation identified R6's wound progress "stalled" and R6 continued to scratch the wound and remove the dressing herself. Wound dressing stayed the same. In addition, R6 was educated on the importance of not scratching to allow proper healing of the wound and advised to allow the dressing to remain in place. A subsequent Skin and Wound Evaluation V5.0 dated 7/26/22, identified R6 had a right shin rash which was slow to heal. The evaluation was uncompleted. R6's progress notes identified the following entries: -5/31/22: R6 was observed to have "an open area at the back of her left leg." -6/7/22: R6 was alert to self with confusion. She was seen by the wound doctor and "no changes were made on her treatment orders." -6/28/22: R6 was not assessed during wound rounds secondary to her being non-compliant at time of rounds. -7/14/22: R6 was confused and "both feet are open and weepy, washed with soap and water and then cleanser, Xeroform applied and wrapped with calyx." -8/1/22, at 1:21 p.m. R6 was noncompliant with her dressing change treatment. "The incoming nurse was notified of [R6's] non cooperation to try and change the wounds at the end of the shift." -8/1/22, at 10:09 p.m. R6's daughter was updated related to R6's "complicated impaired wound bed." -8/1/22, at 10:14 p.m. R6's on-call provider updated on wound status and provided an order to send R6 to the emergency room to evaluate	F 684		

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F 684	Continued From page 22 and treat her bilateral wound extremities. 8/1/22, at 11:54 p.m. R6 was alert and oriented to self with some confusion. "Her bilateral wounds on her feet were severely affected [sic] and multiple maggots were presenting from the wounds." At 11:10 p.m. R6 was sent to the hospital. R6's progress notes, dated 7/27/22 - 8/1/22, at 1:21 p.m. lacked evidence R6 refused wound care treatments or that on 7/27/22, R6's family completed the dressing change. When interviewed on 8/4/22, at 3:15 p.m. LPN-E stated she worked with R6 on the evening of 8/1/22, and provided her wound treatments. She explained the day nurse updated her R6 refused her day shift dressing change and asked LPN-E to complete it. That evening LPN-E started to encourage R6 to return to her room around 7:30 p.m., as she refused her shower despite multiple attempts that shift, in order for her to at least complete R6's dressing change. It took R6 "two hours" before she complied. When LPN-E opened the left leg wound dressing, she stated, "I realized it was infected. The maggots started coming out ..." LPN-E confirmed she did not count the maggots as "they just dropped on the floor;" however, stated there were more than one but not 10 of them, and she described them as white in color and about a centimeter long. LPN-E stated the wound "was not draining" and the dressing "was not clean;" however, she described the dressing as if had lotion or Vaseline on it which then picked up debris when R6 rubbed up against things and it stuck to the dressing. She added because R6 preferred to wear dresses, the dressings were exposed and got dirty. Lastly, LPN-E stated she did not recall if there was a date on the dressing when she removed it.	F 684		

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F 684	Continued From page 23 During a telephone interview on 8/5/22, at 8:46 a.m. the wound care physician (WCP) stated she provided weekly resident wound care rounds in which rounds consisted typically of the nurse manager (LPN)-B, a nurse if available, and then a nursing assistant (NA) would follow when first floor wound rounds were conducted. She explained staff prepare the residents for her visit in which either she or the staff removed the old dressings. She then examined and assessed the wounds in which LPN-B took notes related to suggested wound care treatment changes and/or recommendations. Once the visit was over, the nurse would complete the ordered treatment. She confirmed she did not review each resident's medical record (progress notes/MAR/TAR) during each visit to review the orders and to ensure her orders were being carried out as she prescribed. She explained that was the facility's responsibility. She stated when she observed "something [dressing] missing" she inquired if the order was on the MAR/TAR. The WCP confirmed she observed "probably one or two patients every week" with incorrectly performed wound care treatments which she stated was "more common if I changed the dressing" the previous visit. She continued there were times when there was "a lag on getting the dressing that I ordered ...I am not sure what happens." She acknowledged there were also times when she was required to inquire as to the whereabouts of an ordered dressing or the Santyl. She stated, "It has been an ongoing process to fix it [supply issues]." She responded she "generally" is not updated on facility issues related to order clarification requests and/or issues related to obtaining ordered treatment supplies. She typically found out about concerns when she returned to the facility the following	F 684		

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F 684	Continued From page 24 week. The WCP verbalized she had spoken to the DON about her concerns; however, she had not drilled down to find out the reasons for the concerns: "It would seem there should be a uniform process." When the WCP ordered wound treatments she had specific thoughts in mind and rationalizations as to why she chose, or did not choose, a particular treatment. She explained if a resident was provided wound care treatment(s) she did not order, the treatment error would make it more difficult for her to evaluate and assess the wound: "It slows down the evaluation process" and the wound may show a failure to progress." The wound may also decline and/or the wound may develop moisture associated skin damage if staff failed to provide a barrier cream. The WCP stated her dictated progress notes, with updated orders, were available to the staff the same day as the wound rounds in which she expected the staff to review the dictation for any order or recommendation adjustments. and/or the need for any clarifications. and then process her orders and recommendations as written. The WCP stated, " ...in general they are trying very hard and it seems they need some guidance on the process. It is not just measuring the wounds ...the orders need to be in and done correctly. Supplies need to be in the facility and in the room and they may need some process changes or at least to look at that process." The WCP stated during wound rounds on 7/26/22, R6's wound was assessed to have deteriorated; however, the wound was free from signs and symptoms of infection or maggots. She was unable to comment on information related to maggots in a wound; however, she did not feel that the application of incorrect dressings would have caused them. She explained she had reviewed some literature and read maggots were not a	F 684		

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F 684	Continued From page 25	F 684		

hygiene concern, but a fly issue. She stated she had not observed R6's dressings off when she visited and did not have issues with dirty dressings; however, she commented, "If [staff] were covering [the legs] and the dressings were on, it is hard to say that it led to the maggots." The WCP stated with the 7/26/22 rounds, R6's legs looked "wetter" and thus she ordered the Santyl to debride them. She again stated she expected staff to process her orders and follow them as directed. When the WCP was questioned about R6's therapy order, she confirmed she did not know if the recommendation was completed: "I would have expected it to be done or an explanation [as to why not completed]." She acknowledged she was not aware R6 worked with PT since she started wound rounds with her.

When interviewed on 8/5/22, at 1:08 p.m. R6's FM-B stated when she arrived on 7/27/22, R6 lacked dressings to her legs as R6 sat in the day room. The legs were "oozing clear liquid and bleeding profusely." FM-B explained she walked her back to her room and she provided wound care to R6's legs. She cleansed the wounds with wound cleaner and wrapped the legs with gauze after she "sterilized everything and used gloves." FM-B stated she had attempted to ask the nurse to apply dressings to R6's legs; however, she explained "they were getting him to work somewhere else." FM-B stated she had not visited with R6 between the time she changed her dressings on 7/27/22 and when she arrived back to the facility on 8/1/22.

During interview on 8/5/22, at 2:05 p.m. LPN-C stated when an order was received the health unit coordinator (HUC) initially entered the order into

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F 684	Continued From page 26 the MAR/TAR. After, a nurse performed a double check. LPN-C explained wound care provider orders were processed "like any other doctor." He confirmed orders were expected to be processed exactly how the order was written by the provider and the order was expected to be followed. LPN-C stated if orders were not processed or followed risks to the residents may occur: "It would depend on what the error was." He provided a verbal example in which during dressing changes he had personally observed an "ABD" or a "Mepilex" on a resident; however, upon his review of the MAR/TAR, these types of dressings were not the active order. LPN-C explained if the wrong dressing or treatment was observed, he reviewed the MAR/TAR and it was not his overall practice to review the actual provider order. LPN-C acknowledged discussions with the nurse manager about such concerns and other medication order process concerns and verbalized he was not involved in the weekly wound round process. He verbalized R6's dressings came off at night and in the morning she would not have dressings on [based on R6's wound care orders, her wounds would always be covered]. LPN-C confirmed on the morning of 7/27/22, he observed R6 without dressings on her legs and her legs were bleeding. On 7/27/22, around lunch time, FM-B approached him after they arrived and asked if he could apply R6's dressings. He stated he informed FM-B he needed to address another resident's concern at that moment. Around 11:00 a.m. LPN-C observed Kerlix on R6's legs and he learned FM-B had applied it. LPN-C stated as soon as FM-B left the facility, he assisted R6 back to her room and re-applied the ordered dressings. He confirmed FM-B applied "just plain gauze dressing." LPN-C denied he dated the dressing on 7/27/22;	F 684		

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F 684	Continued From page 27 however, he acknowledged he should have dated the dressing and he should have documented that days dressing change status. When interviewed on 8/5/22, at 2:50 p.m. the evening nurse supervisor (LPN)-D stated when she received orders or order changes she processed them and then the order was double checked by another nurse. She expected the order to be processed as written and if the nurse questioned the order the provider was to be updated for clarifications. Further, she expected the nurses to follow the orders as prescribed. LPN-D confirmed Adaptic and Xeroform were not the same dressing and expected to see Xeroform on a wound if that was the dressing ordered and not Adaptic. She explained if a wound care order was not followed as prescribed, "That might cause the wound to deteriorate." She confirmed she was unaware of any current concerns related to staff not following provider orders or nurses finding non-ordered dressings on residents. Further, she confirmed she was not aware of any wound treatment supply issues. LPN-D acknowledged she observed R6's leg on 7/27/22, and witnessed "multiple maggots." She denied she had observed a date on R6's dressing that evening and explained the dressing was dry and a "brownish dark color" was on the inside of the dressing. She denied the wound had any odor and reported "it really did not look different" from the last time she had observed it. On 8/5/22, at 3:15 p.m. the director of rehab (DOR) and physical therapist (PT)-A were interviewed together. The DOR reviewed R6's therapy notes and confirmed therapy was not updated on the WCP's 6/24/22, therapy orders; however, she explained R6 was involved with	F 684		

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therapy from 5/2/22 through 7/22/22. PT-A stated he was not involved in R6's wound care; however, he provided her with full body lymphedema treatment and he worked with her on lymphedema wraps. He acknowledged R6 only allowed them for very short periods of time and then she made attempts to remove them herself. The DOR stated she would expect nursing staff to update her related to any provider orders for therapy, even if they already worked with the resident, to ensure what was ordered was already part of the resident's treatment plan.

When interviewed on 8/9/22, at 11:49 a.m. LPN-B stated he started the nurse manager role in May (approximately two months prior). He explained during wound rounds he took notes based on comments provided by the WCP, and once the WCP completed her dictated reports, he reviewed them and ensured the orders in the MAR/TAR were updated and/or current. He explained he or the nurses could process the WCP orders and stated he expected the order for the WCP and the order entered into the MAR/TAR were exact. He confirmed all orders were expected to be double checked and co-signed on the order sheet and then the HUC would scan the order into the medical record. LPN-B stated the WCP did not send "regular" orders and "they just get scanned in." He confirmed he did not co-sign the WCP orders or that he asked another nurse to double check the orders; however, if another nurse was to process the WCP orders, he expected them to have another nurse co-sign them. He stated processing and following the WCP orders were expected and were important to help minimize the risk of the wound "getting out of hand" such as infection or decreased healing. He acknowledged

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F 684	Continued From page 29 he printed out the orders and went through them one at a time to check them for accuracy and indicated it was "a lot for one person." In addition, he acknowledged he lacked any observations the wrong dressings or treatments were provided to residents. He confirmed the facility experienced no recent order supply concerns. LPN-B stated he performed R6's dressing change on 7/30/22, in which he did not observe any concerns. He explained R6 took her dressings off herself and staff could change her dressings and there was "no guarantee it is going to stay there. That is why there is a two times day dressing changes." He acknowledged he expected nurses to place a dressing on R6's legs as directed, if R6's legs lacked a dressing. He explained the dressings served a purpose of helping to improve healing and to decrease edema. LPN-B stated R6 had not declined dressing changes for him and he was unaware she declined them for other nurses. When LPN-B was questioned on Adaptic or Xeroform dressings, he was unable to answer if they were the same dressing or different; however, he stated, "What is in the MAR and TAR is what is expected to follow. If staff have questions they can reference the orders from the doctor." During interview on 8/9/22, at 1:39 p.m. the DON stated the WCP dictated notes and orders did not come the traditional way as other provider orders were received. She confirmed the WCP dictation and orders were available for review within 24 hours in which nurse management and leadership was responsible to make sure the orders were updated, current, and processed as wrote by the WCP. In addition, she expected staff to follow the order as prescribed and if there were concerns identified with the order, the provider	F 684		

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F 684	Continued From page 30 was to be contacted for clarification. The DON stated if staff failed to follow an order as prescribed staff were not doing what they were expected to do, which could cause a wound infection. The DON stated during a conversation with R6's FM-B on 8/1/22, FM-B changed R6's dressings on 7/27/22. Staff failed to notify her of this incident. In addition, FM-B informed her no one had changed R6's dressings since. The DON explained during her investigation into R6's wound being found with maggots the dressings were changed by staff despite FM-B's statements they had not. When the DON was questioned as to why the 8/1/22, FRI indicated the dressing was not changed for three days, she explained she "panicked" and took FM-B's initial statements into account and "I thought the worst." The DON confirmed Adaptic and Xeroform are different dressings in which Xeroform "is more medicated." She explained a lot of their seasoned nurses have left which may be one reason for some of the wound care/dressing concerns. She stated, when she first started in April, "there were definite education issues" and she commented it appeared as if they needed to have the wound care supply representative out to the facility for staff training. A policy for physician order processing and transcription was requested. An undated policy Medication and Treatment Orders was provided and identified the policy's purpose was for medication and treatment orders to be consistent with principles of safe and effective order writing. The policy identified drug and biological orders were to be recorded on the Physician's Order Sheet in the resident's chart. The policy lacked direction on the facility's process for nurse order processing and transcription or expectations	F 684		

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F 684	Continued From page 31 related to medication and/or treatment administration. An undated policy Wound Care identified the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The policy directed staff to verify the physician order prior to the treatment and document specific information in the resident's medical record after completion i.e. type of wound care provided, any changes in the resident's condition, all assessment data obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints reported, and if the resident refused the treatment and the reason why. In addition, the policy directed to notify the supervisor if the resident refused the wound care and to report other information in accordance with facility policy and professional standards of practice.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		9/3/22

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F 686	Continued From page 32 by: Based on interview and document review, the facility failed to ensure residents identified at risk for worsening pressure ulcers received the necessary care and treatment to decrease the risk of worsening wounds and decreased healing for 1 of 1 residents (R7) who in the sample of residents was identified to have a pressure ulcer and who followed the rounding wound care physician. Findings include: R7's hospital History and Physical, dated 12/3/21, identified R7 presented to the hospital with a sacral decubitus (pressure) ulcer. R7's quarterly Minimum Data Set (MDS), dated 7/8/22, identified R7 was severely cognitive impaired and was free of exhibited rejection of care(s). She required extensive physical assist for mobility and cares and experienced total bladder and bowel incontinence. Diagnosis included dementia, morbid obesity, weakness, and a sacral region pressure ulcer. In addition, the MDS identified R7 was at risk for pressure ulcers based on formalized and clinical assessments in which R7 presented with a stage 4 pressure ulcer and pressure ulcer care. R7's Care Plan, printed 8/9/22, identified R7 was dependent on staff for " ...intellectual, physical ...needs r/t (related to) cognitive deficits, immobility, and physical limitations. Her ADL (activities of daily living) care needs directed staff to use extensive assistance to assist R7 to turn and reposition in bed and her Care Plan identified R7 presented with a stage 4 pressure ulcer on her coccyx r/t immobility. Interventions included	F 686	F686 1. Immediate action(s) taken for the identified problem include: Nursing staff completed skin assessments on all residents that currently had wounds. 2. Identification of similar occurrences of the problem was accomplished by: All residents have the potential to be affected by this type of situation. 3. Actions taken/systemic changes put into place to ensure deficient practice will not recur: Nursing staff to be re-educated on wound care orders, process and supplies. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Wound round progress notes to be audited by DON and/or designee to monitor for accuracy in addition to shadowing of nurses while they do treatments weekly to ensure accuracy of implantation of treatment order as well as appropriate hand hygiene Any issues will be reported at QAPI. Corrective action completion date: 9/3/2022	

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F 686	Continued From page 33 the following: administer treatments as ordered and monitor for effectiveness, avoid positioning on coccyx for extended periods of time, encourage and assist to shift weight in wheelchair every 15 minutes, if treatments refused, confer with her, IDT (interdisciplinary team), and family to determine why and to try alternative methods, assist to turn/reposition at least every two hours, more often as needed or requested. Vohra Wound Physicians Initial Wound Evaluation and Management Summary, dated 1/4/22, identified R7 was examined to have a stage 4 sacral pressure ulcer (6cm (centimiters -length) x 5cm (width) x 3cm (depth); 30cm surface area (length x width); 10% slough (dead tissue); 90% granulation (signs of healing tissue). Initial provider orders were as follows: -Leptospermum Honey [Medihoney] BID (twice a day) applied to the wound base. -Alginate Calcium (dressing) BID -Gauze Roll (Kerlix) BID - pack remainder of wound with fluffed Kerlix and cover with a foam border dressing. R7's MAR/TAR (medication/treatment administration record(s) dated 1/4/22 - 4/19/22, lacked evidence staff were directed to pack the wound with "fluffed" Kerlix. In addition, her MAR/TAR dated 1/4/22 - 4/19/22, indicated a PRN (as needed) order for coccyx wound dressing changes; however, the orders from 1/4/22 - 8/4/22 lack evidence of a PRN order. Subsequent Vohra visits identified the following information: -1/18/22: the wound progress improved. During the visit she was initially evaluated to have diagnosis of lichenification and "Moisturizer to areas of dry skin daily" was ordered. R7's	F 686		

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F 686	Continued From page 34 MAR/TAR dated 1/18/22 - 8/4/22, lacked evidence the moisturizer order was initiated. -1/25/22: the wound progress remained unchanged (5cm x 4cm x 2cm; 20cm surface area with undermining 1.5cm at three o'clock, 5% necrotic (hard dead tissue); 5% slough (dead tissue) 90% granulation). A "purplish discoloration of left side of wound bed" was observed and the provider recommended "[R7] to rest more on right side to alleviate pressure on left side of wound." R7's MAR/TAR dated 1/25/22 - 8/4/22, directed staff to turn and reposition R7 every two hours and lacked evidence of the order to rest more on her right side. -3/10/22: the wound progress deteriorated (5cm x 4cm x 3cm; 10cm surface area; 60% granulation; 40% "other viable tissues" 40% muscle) "due to patient non-compliant with wound care." The provider recommended "limit sitting to one hour up in chair or wheelchair, then one hour of resting on side." R7's MAR/TAR dated 3/10/22 - 8/4/22, lacked evidence the order was initiated. -4/5/22: the wound progress improved. -4/19/22: the wound progress remained unchanged (4cm x 3cm x 2cm; 12cm surface area; 20% slough; 40% granulation; 40% muscle); however, an order was provided for Santyl (enzymatic debriding agent) once a day (QD) to be applied to the wound after the wound was cleansed with wound cleanser. The Alginate Calcium order continued for BID. The honey application was discontinued. R7's MAR/TAR dated 4/19/22 - 8/4/22 directed staff to apply Santyl after the wound was cleansed and then to cover with calcium alginate, pack with Kerlix, and cover with an ABD (high absorbency) dressing and tape BID; however, the MAR/TAR lacked evidence of the once a day Santyl application was initiated. In addition, R7's medical record/wound	F 686		

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F 686	Continued From page 35 care orders continued to direct a foam border dressing and she lacked an order for ABD dressing and tape. Furthermore, the MAR/TAR indicated the Medihoney order ended on 4/22/22, not as ordered on 4/19/22. -4/26/22: the wound progress deteriorated (5cm x 2.7cm x 2cm; 13.5cm surface area; 60% slough; 20% granulation; 20% muscle) and the Alginate Calcium, Kerlix, and foam border dressing order was changed to an QD application (the BID order was discontinued). An Additional Wound Detail note indicated the "DON will review dressing application with nursing." R7's MAR/TAR dated 4/26/22 - 8/4/22, directed BID wound care dressing changes and lacked evidence the order was changed to QD. -5/3/22: the wound progress remained unchanged. An Additional Wound Detail note indicated "Application of Santyl demonstrated to nursing." -5/17/22: the wound progress improved (4.5cm x 3.7cm x 2cm; 16.65cm surface area; continued undermining; 30% slough; 50% granulation; 20% muscle; however, an order for house barrier cream to be applied around the wound perimeter QD was provided. R7's MAR/TAR dated 5/17/22 - 8/4/22 lacked evidence of a barrier cream order. -6/7/22: the wound progress deteriorated (5.9cm x 4.7cm x 1.5cm; 27.73cm surface area; continued undermining; 20% slough; 60% granulation; 20% muscle). -6/14/22: the wound progress improved. On 6/14/22, R7's MAR/TAR was updated and directed staff to utilize skin prep to the wound edges before the ABD was applied. R7's wound care orders or medical record lacked evidence of a skin prep order and/or the use of an ABD. -7/5/22: the wound progress remained unchanged.	F 686		

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F 686	Continued From page 36 -7/12/22: the wound progress remained unchanged. Negative pressure wound therapy (VAC) was ordered to be applied three times per week. The Alginate Calcium, Kerlix, Santyl and foam border were discontinued. R7's MAR/TAR dated 7/12/22, lacked evidence of a VAC order or that the Santyl and dressings were stopped. -7/19/22: the wound progress remained unchanged (4cm x 5.4cm x 1cm; 21.60cm surface area; 1.5cm continued undermining; 20% slough; 60% granulation; 20% muscle. The VAC order continued. An Additional Wound Detail note indicated "Wound VAC not yet available." No additional wound care orders were provided. -7/26/22: the wound progress improved. An Additional Wound Detail note indicated "Wound VAC not yet in place. DON has been asked to facilitate." No additional wound care orders were provided. -8/2/22: the wound progress improved (5cm x 3.7cm x 1cm; 18.50cm surface area; 1.5cm continued undermining; 10% slough; 70% granulation; 20% muscle). An Additional Wound Detail note indicated "[R7] did not tolerate wound VAC. Periwound erythema developed with VAC. Tx (treatment) now with barrier cream." VAC orders continued; however, Alginate Calcium, Santyl, and a superabsorbent silicone border dressing once a day was ordered. R7's MAR/TAR dated 8/2/22 - 8/4/22 lacked evidence of the new order or the barrier cream. From 7/12/22 - 8/4/22, R7's MAR/TAR lacked evidence the VAC was initiated and continued to direct staff to apply Santyl and the dressings BID. Her medical record lacked evidence the wound care physician (WCP) was updated between wound care rounds related to any VAC complications or to question the need for continued dressing order(s) until the VAC could	F 686		

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F 686	Continued From page 37 be initiated. R7's progress notes identified the following entries: -5/10/22: "[R7] seen by Wound Dr and noted that incorrect alginate being used with Santyl. Licensed staff and Writer [DON] replaced incorrect treatment dressing in designated wound bucket ..." -5/10/22: "[DON] has updated wound treatment to include the following: calcium should not be cut and box removed from should be green. If not in wound supplies in [R7's] room alert DON and/or facility leadership prior to completing dressing change." -From 7/12/22 - 7/28/22, R7's progress notes lacked evidence a VAC was discussed with R7 or family, was ordered, was applied, and/or a rationalization as to why the VAC order was not initiated on 7/12/22 with initial order or on 7/19/22 and 7/26/22 with the continued VAC orders. In addition, the progress notes lacked evidence the wound care provider was updated related to the VAC directed orders not being initiated or performed. -7/29/22 (a late entry recorded on 8/3/22): "A wound VAC was applied as per the wound doctor order. Resident initially complained of the wound vac being uncomfortable. Resident will continue to be monitored and subsequent changes will be to provide resident more comfort." -From 7/29/22 - 8/2/22: R7's progress note lacked documentation related to the VAC. -8/3/22: "her bottom is red in patches some from the tape removal. The wound edges are whitish and the skin is pealing [sic] off in some areas. [R7] has an order for negative pressure therapy but the wound vac is missing, and so the writer	F 686		

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F 686	Continued From page 38 did Santyl and silver alginate and ABD was used, the DON, nurse manager and family were notified. The management will call the wound doc for new orders till the wound vac issue is resolved. In coming nurse was updated." [on 8/2/22 wound care provider was updated (per her dictation) that R7 did not tolerate the VAC and she provided new orders for Alginate Calcium, Santyl and a superabsorbent silicone border dressing QD]. -From 8/3/22 - 8/9/22, R7's progress notes lack evidence the wound care provider was updated related to R7's 8/3/22 progress note and/or to obtain an order to officially discontinue the 8/2/22 continued VAC order. -8/4/22: "[DON has reached out to Custom Medical regarding the following inquiry: Was wound vac picked up not showing up in here to reflect she has one here. It has been discontinued by the Dr per family request; response pending." -From 8/4/22 - 8/9/22, R7's progress notes lacked evidence the VAC was found or discontinued. When interviewed on 8/4/22, at 3:15 p.m. LPN-E stated she was responsible for processing orders and explained either the health unit coordinator (HUC) or a nurse initially processed the order and then a nurse was required to double check it. She stated once staff completed the order process, they were required to sign the order to verify it was completed. LPN-E denied she processed orders from the WCP and was unsure as to the orders process when the WCP completed wound rounds on Tuesdays. She confirmed nurses were expected to follow what the MAR/TAR directed and if there were concerns, they were expected to update the provider for clarification. LPN-E acknowledged a first floor resident recently	F 686		

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F 686	Continued From page 39 received VAC treatment; however, she was unaware of any residents on other floors that received recent VAC orders. She stated R7 required a dressing change every evening. She was unsure as to what R7's day shift orders were. She stated she was unaware R7 was recently ordered to try a VAC and R7 was ordered for every two hour repositioning. LPN-E explained R7 propelled herself around the unit with her wheelchair and was compliant with the every two hour repositioning; however, she commented R7 was often in her wheelchair during the evening shift and staff attempted to encourage her to lay down right after supper: "If she is ready." She denied R7 took naps or laid in bed during the evening shift when she worked. During a telephone interview on 8/5/22, at 8:46 a.m. WCP stated she provided weekly resident wound care rounds in which rounds consisted typically of the nurse manager (LPN)-B, a nurse if available, and then a nursing assistant (NA) would follow when first floor wound rounds were conducted. She explained staff prepare the residents for her visit in which either she or the staff removed the old dressings. She then examined and assessed the wounds in which LPN-B took notes related to suggested wound care treatment changes and/or recommendations. Once the visit was over, the nurse would complete the ordered treatment. She confirmed she did not review each resident's medical record (progress notes/MAR/TAR) during each visit to review the orders and to ensure her orders were being carried out as she prescribed. She explained that was the facility's responsibility. She stated when she observed "something [dressing] missing" she inquired if the order was on the MAR/TAR. The WCP confirmed she	F 686		

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F 686	Continued From page 40 observed "probably one or two patients every week" with incorrectly performed wound care treatments which she stated was "more common if I changed the dressing" the previous visit. She continued there were times when there was "a lag on getting the dressing that I ordered ...I am not sure what happens." She acknowledged there were also times when she was required to inquire as to the whereabouts of an ordered dressing or the Santyl. She stated "it has been an ongoing process to fix it [supply issues]." She responded she "generally" is not updated on facility issues related to order clarification requests and/or issues related to obtaining ordered treatment supplies. She typically found out about concerns when she returned to the facility the following week. The WCP verbalized she had spoken to the DON about her concerns; however, she had not drilled down to find out the reasons for the concerns: "It would seem there should be a uniform process." When the WCP ordered wound treatments she had specific thoughts in mind and rationalizations as to why she choose, or did not choose, a particular treatment. She explained if a resident was provided wound care treatment(s) she did not order, the treatment error would make it more difficult for her to evaluate and assess the wound: "It slows down the evaluation process" and the wound may show a "failure to progress." The wound may also decline and/or the wound may develop moisture associated skin damage if staff failed to provide a barrier cream. The WCP stated her dictated progress notes, with updated orders, were available to the staff the same day as the wound rounds in which she expected the staff to review the dictation for any order or recommendation adjustments. and/or the need for any clarifications. and then process her orders and recommendations as written. The WCP	F 686		

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F 686	Continued From page 41 stated " ...in general they are trying very hard and it seems they need some guidance on the process. It is not just measuring the wounds ...the orders need to be in and done correctly. Supplies need to be in the facility and in the room and they may need some process changes or at least to look at that process." The WCP stated R7's sacral ulcer "kind of plateaued" and she started to develop slough in the wound so she ordered Santyl. She explained R7 had utilized a VAC upon admission; however, at that time she failed to tolerate the treatment and it was discontinued; however, when R7's wound started to produce less drainage and appeared to be getting smaller in size, with R7 experiencing decreased complaints of wound pain and increased ability to assist with bed mobility, the WCP discussed with R7's husband reapplying the VAC. She explained the VAC was not in place when she returned for wound rounds the following week after she initially ordered it. She stated staff informed her the DON wished to have a conversation with R7's husband as the DON was told by staff he did not want the VAC placed on R7. The WCP asked staff to double check on that information and informed the staff the husband had okayed a trial use of the VAC with her conversation, and if R7 did not tolerate, they would discontinue it. The week following, the WCP did not observe the VAC in place and she stated she was informed the facility did not have the VAC. She explained she emailed the DON and she was informed by facility staff someone was going to order it. With her most recent visit on 8/2/22, she stated staff informed her staff applied the VAC to R7; however, "she did not tolerate it." The WCP confirmed she did not review R7's medical record after she ordered the VAC to determine if her orders for R7 were followed. She explained, "I	F 686		

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F 686	Continued From page 42 would have a low bar for making [R7] use [the VAC] but I thought she might be fine if they bridged it ...her wound has stalled out and it is a deeper wound, and a wound that if we had this, someone would put a VAC on it to bring it together." Further, she explained she ordered the VAC as R7's husband indicated he was attempting to discharge R7 to another facility to be closer to him and she felt this would help facilitate such a move as the treatment would only be three times a week, not daily. The WCP, when questioned on her expectations for recommendations, confirmed the recommendations were to be treated as orders and were to be processed as such. She confirmed her recommendation for R7's hourly repositioning should be in her orders and in her care plan. If R7 declined the recommendation as ordered, she expected to see progress notes which indicated the refusals and that she were updated. If repositioning recommendations were not followed, she explained the wound could get larger and deeper. She stated, " ...maybe it [R7's wound] would have gotten smaller faster if they would have followed that order." During interview on 8/5/22, at 2:05 p.m. LPN-C stated when an order was received the health unit coordinator (HUC) initially entered the order into the MAR/TAR. After, a nurse performed a double check. LPN-C explained wound care provider orders were processed "like any other doctor." He confirmed orders were expected to be processed exactly how the order was wrote by the provider and the order was expected to be followed. LPN-C stated if orders were not processed or followed risks to the residents may occur: "It would depend on what the error was." He provided a verbal example in which during	F 686		

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F 686	Continued From page 43 dressing changes he had personally observed an "ABD" or a "Mepilex" on a resident; however, upon his review of the MAR/TAR, these types of dressings were not the active order. LPN-C explained if the wrong dressing or treatment was observed, he reviewed the MAR/TAR and it was not his overall practice to review the actual provider order. LPN-C acknowledged discussions with the nurse manager about such concerns and other medication order process concerns and verbalized he was not involved in the weekly wound round process. When interviewed on 8/5/22, at 2:50 p.m. the evening nurse supervisor (LPN)-D stated when she received orders or order changes she processed them and then the order was double checked by another nurse. She expected the order to be processed as wrote and if the nurse questioned the order the provider was to be updated for clarifications. Further, she expected the nurses to follow the orders as prescribed. She explained, if a wound care order was not followed as prescribed, "That might cause the wound to deteriorate." She confirmed she was unaware of any current concerns related to staff not following provider orders or nurses finding non-ordered dressings on residents. Further, she confirmed she was not aware of any wound treatment supply issues. She denied knowledge of any residents recently being ordered a VAC and/or issues obtaining a VAC if one were ordered. She acknowledged if a VAC order was not processed, for any reason, the provider was to be updated for additional orders until the VAC situation was fixed. During a telephone interview on 8/9/22, at 10:24 a.m. R7's family member (FM)-A stated he had	F 686		

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F 686	Continued From page 44 issues with R7's wound care. He explained staff do not follow the physician orders and reported he had observed her wound to be "open" and no dressings in place. He acknowledged this happened "maybe three times in the seven months she has been there." He verbalized this concern improved after the last time and his conversation with the WCP when he updated her on his concerns and she informed him she would talk to someone; however, he expressed his frustration related to R7's recent VAC order. He explained he conversed with the WCP "the last three weeks" related to the VAC and he confirmed he initially agreed for R7 to attempt the VAC again "for a little while to see if it can get it to close a little quicker" and if R7 did not tolerate it, the VAC would be discontinued. FM-A stated he visited R7 at a minimum three days a week and he confirmed he did not observe the VAC on R7's wound and further confirmed the staff did not talk with him about any attempted application of the VAC and/or if they did how R7 tolerated it. When interviewed on 8/9/22, at 11:49 a.m. LPN-B stated he started the nurse manager role in May (approximately two months prior). He explained during wound rounds he took notes based on comments provided by the WCP, and once the WCP completed her dictated reports, he reviewed them and ensured the orders in the MAR/TAR were updated and/or current. He explained he or the nurses could process the WCP orders and stated he expected the order for the WCP and the order entered into the MAR/TAR were exact. He confirmed all orders were expected to be double checked and co-signed on the order sheet and then the HUC would scan the order into the medical record. LPN-B stated the WCP did not send "regular"	F 686		

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F 686	Continued From page 45 orders and "they just get scanned in." He confirmed he did not co-sign the WCP orders or that he asked another nurse to double check the orders; however, if another nurse was to process the WCP orders, he expected them to have another nurse co-sign them. He stated processing and following the WCP orders were expected and were important to help minimize the risk of the wound "getting out of hand" such as infection or decreased healing. He acknowledged he printed out the orders and went through them one at a time to check them for accuracy and indicated it was "a lot for one person." In addition, he acknowledged he lacked any observations the wrong dressings or treatments were provided to residents. He confirmed the facility experienced no recent order supply concerns. LPN-B stated, on 7/29/22, he initially applied the VAC to R7 and then on 7/30/22 he reapplied it as R7 "messed with it." He confirmed these were the only two days R7 utilized the VAC per his knowledge. He indicated staff found the VAC that morning (8/9/22) after it was reported missing. LPN-B explained R7's family was "indecisive" with the initial VAC order and once R7's husband agreed to the treatment, they ordered the VAC. When questioned why R7's MAR/TAR lacked the VAC order, after his review of her orders, he expressed he was unsure and confirmed the order was not processed. In addition, he acknowledged the VAC order was expected to be in her MAR/TAR, along with any documentation related to the VAC placement, R7's reaction to the VAC, and reason for its discontinuation. LPN-B stated R7 was not a resident who tampered with her dressings and her husband was often her to help keep an eye on her so she did not. He identified R7 was to be turned and repositioned every two hours and he commented,	F 686		

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F 686	Continued From page 46 "Most of the time she is out and about with her husband and in the wheelchair." He acknowledged, after review of the WCP recommendations for repositioning, that R7 should have an order for the hourly repositioning. He verbalized increased repositioning for R7 may have assisted in promoting healing and there was a risk of delayed healing for R7 as she was not repositioned per the WCP recommendations. During interview on 8/9/22, at 1:39 p.m. the DON stated the WCP dictated notes and orders did not come the traditional way as other provider orders were received. She confirmed the WCP dictation and orders were available for review within 24 hours in which nurse management and leadership was responsible to make sure the orders were updated, current, and processed as wrote by the WCP. In addition, she expected staff to follow the order as prescribed and if there were concerns identified with the order, the provider was to be contacted for clarification. The DON stated if staff failed to follow an order as prescribed staff were not doing what they were expected to do, which could cause a wound infection. The DON confirmed there were issues with R7's VAC order being implemented, mainly related to concerns with facility, family, and WCP conversations not aligning. She stated R7's VAC orders should have been processed when it was originally ordered and confirmed she had not yet followed up with LPN-B related to her documentation and order processing concerns related to R7. A policy for physician order processing and transcription was requested. An undated policy Medication and Treatment Orders was provided and identified the policy's purpose was for	F 686		

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F 686	Continued From page 47 medication and treatment orders to be consistent with principles of safe and effective order writing. The policy identified drug and biological orders were to be recorded on the Physician's Order Sheet in the resident's chart. The policy lacked direction on the facility's process for nurse order processing and transcription or expectations related to medication and/or treatment administration. An undated policy Wound Care identified the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The policy directed staff to verify the physician order prior to the treatment and document specific information in the resident's medical record after completion i.e. type of wound care provided, any changes in the resident's condition, all assessment data obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints reported, and if the resident refused the treatment and the reason why. In addition, the policy directed to notify the supervisor if the resident refused the wound care and to report other information in accordance with facility policy and professional standards of practice.	F 686		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 744	F744	9/3/22

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F 744	Continued From page 48 review, the facility failed to assess and re-assess to develop and implement a person centered dementia care treatment plan and failed to follow outside professional help's recommendations for 1 of 1 resident (R1) reviewed who had behaviors related to dementia. Findings include: R1's annual minimal data set (MDS) dated 6/6/22, indicated R1 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R1 did not exhibit physical behaviors. R1's care plan dated 12/11/19, indicated R1 was physically aggressive (hitting other residents) related to diagnoses of dementia and depression. Further R1's care plan directed staff to administer medications as ordered, assess and anticipate needs, modify environment (reduce noise, place familiar objects in room), and when R1 become agitated intervene before agitation escalates, guide aware from source of distress, engage calmly in conversation, if response from R1 continues to be aggressive staff are to walk away calmly and approach later. R1's care plan lacked evidence R1 had been re-assessed following increased physical behaviors to develop appropriate interventions following recent incidents of R1 physically abusing other residents, or threatening behaviors directed towards other residents to safeguard vulnerable residents living with/near or vicinity of R1, and R1's rejection of care from staff. R1's Associated Clinic of Psychology (ACP) visit note dated 7/6/22, indicated R1's referral to ACP services was related to sporadic behavior	F 744	1. Immediate action(s) taken for the identified problem include: IDT revised resident's care plan with interventions to promote less physically aggressive behaviors towards other residents on unit. Care plan, care plan guides and nursing report sheets all updated to reflect interventions put in place for resident. R6 was moved to private room. 2. Identification of similar occurrences of the problem was accomplished by: All residents have the potential to be affected by this type of situation. The IDT assessed other who may require dementia related care and made revisions to care plans as needed. 3. Actions taken/systemic changes put into place to ensure deficient practice will not recur: The policy and procedures regarding care plans and behaviors were reviewed by IDT with no changes made, but all staff re-educated on them. The behavior interdisciplinary team that meets bi-weekly on Thursdays to discuss behavioral issues will now have mandated attendance for the following IDT departments: nursing, therapy, dietary, activities and social services. Minutes to be maintained by nursing and shared with IDT to include the prescribing psychiatrist. Associated Clinic Psychology notes to be reviewed and care plans updated in real time prior to conclusion of that meeting. Staff to be re-educated about this systemic change of the care planning process and behavior management goals upon hire and on quarterly . any changes	

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F 744	Continued From page 49 outbursts and non-compliance. Further, ACP note recommended for R1 to have ACP psychiatric practitioner complete a medication review due to previous reports of behaviors in the recent past and constant sleeping throughout the day. On 8/1/22, at 3:00 p.m. R1 was observed in her room with a magazine and asking for surveyor's assistance to read the magazine. On 8/3/22, at 11:20 a.m. R1 was observed sitting in her wheelchair in the dining room alone and had two coffee cups in front of her. -At 12:53 p.m. TMA-B was observed to assist R1 into the day room, turned on music at a loud level, and walked away from R1 without offering another activity. -during continuous observation starting at 1:27 p.m. surveyor heard screaming coming from the day room (open common area that include nursing station/hallway threshold /day room). Surveyor observed R1 continuing to yell out in the day room while additional staff removed the resident R1 aggressed towards from the day room. R1 remained in the day room with other residents, with no attempt from staff to redirect R1 to other positive activities. -At 1:46 p.m. TMA-B was observed to be at the medication cart at the nursing station and R1 was observed to be upset and making punching actions towards another male resident in the day room. R1 then self-propelled to the resident and kicked him in the leg. TM-B responded and separated the residents and staff removed the male resident from the area. R1 again remained in the day room with other residents, and no facility staff in the proximity or an offer of other positive activities to focus on. R1 was observed to yell, point, and stick her tongue out at a female	F 744	to care plans based on re-assesemenents staff will be trained on. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Audits of the residents care plan to be completed by Social Services to ensure that the behavioral interventions are in place and effective to address the noted behavioral concerns. Daily IDT meetings are held to monitor the on going compliance. QAPI project will be submitted to QAPI committee monthly x3 months, then quarterly thereafter. Corrective action completion date: 9/3/2022	

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F 744	Continued From page 50 resident who was sitting in a stationary chair by the nurse's station. TMA-B returned to the medication cart at the nurse's station. At 1:56 p.m. TMA-B and health unit coordinator (HUC)-B were observed at the nursing station on their computers, while R1 was observed again making faces and sticking out her tongue at the female resident sitting in the chair, neither staff intervened or redirected R1 at that time. R1 began to self-propel in wheelchair towards the female resident and got to the medication cart when TMA-B intervened and redirected R1 with conversation while again removing the other resident from the area. On 8/3/22, at 2:12 p.m. NA-E indicated residents who exhibit behaviors each care plan would direct staff with interventions on what to do when a resident was exhibiting behaviors. In addition, NA-E stated they did not know about R1's behaviors and was not aware of R1 being physically aggressive towards other residents. On 8/2/22, at 10:26 a.m. nursing assistant (NA)-A stated R1 would refuse care and was known to be physically aggressive "a lot". Further, NA-A stated R1 was hard of hearing and would often get upset with staff and residents if they were unable to understand what R1 was saying. NA-A stated interventions were to reapproach and while in the commons area with other residents' staff were expected to "watch" and to sit in the room while R1 was in the commons area. On 8/2/22, at 11:36 a.m. NA-B indicated R1 had confusion and behaviors which consisted of being resistive to cares and physically aggressive towards staff and other residents. NA-B was	F 744		

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F 744	Continued From page 51 unaware of interventions for R1's behaviors related to her dementia. On 8/2/22, at 12:02 p.m. trained medication assistant (TMA)-A stated R1 had an "explosive temper" and "you can't come close to her, or she will hurt you." TMA stated staff were directed to keep other residents away from R1 and watch R1 at a distance. Further, TMA-A indicated R1 was resistive to cares and taking scheduled medications and staff were directed to reapproach R1 later. On 8/2/22, at 12:26 p.m. registered nurse (RN)-A indicated R1 was resistive to cares from staff and would become physically aggressive with staff and residents. Further, RN-A stated staff were expected to reapproach R1 when less agitated, offer for her to lay in bed to rest, or offer books to read. On 8/2/22, at 4:01 p.m. licensed practical nurse (LPN)-A stated R1 would get agitated and "fight" with roommate and at times R1 was difficult to redirect and calm down. LPN-A was unaware of interventions in place for R1's behaviors related to her dementia. On 8/2/22, at 4:53 p.m. social services (SS) stated R1 had physical behaviors and "can't be near most residents". SS stated staff were expected to separate R1 from other residents by 3-4 feet when agitated to give her some space. Further, SS confirmed R1 had not been re-assessed following increased behaviors of physical agression to determine appropriate interventions and R1's care plan had not been updated since December of 2019. SS stated the nursing department would be the ones to update	F 744		

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F 744	Continued From page 52 a resident's behavior and dementia care plans. When asked how a resident's behaviors are monitored, SS-A stated the licensed nurses will document in a progress notes any behaviors and reassess the resident for appropriate behavioral interventions, but SS-A was unsure how staff were monitoring if the behavior interventions were effective. In addition, SS-A indicated R1 was referred to be seen by ACP providers for her behaviors. SS-A stated following each visit with ACP the provider will write a note and SS-A would review the visit note for recommendations which then SS-A would either get new orders or update the care plan if needed. SS-A reviewed R1's ACP visit note dated 7/6/22, and confirmed she did not see the recommendation listed. SS-A stated a medication review by the ACP psychiatric practitioner would have been beneficial for R1 as they could have made medication changes to aid R1 with sleeping better at night and prevent R1 from exhibiting behaviors. In addition, SS-A stated she was not sure if staff were trained related to dementia care and behaviors and felt the staff who work the memory care unit need more education. On 8/3/22, at 10:04 a.m. NA-D indicated R1 had exhibited physically aggressive behaviors and was resistive to care but staff on the memory care unit "don't understand the resident's and don't listen" for example staff would put on a random movie and not one that the residents would like or put on music then R1 would become agitated. In addition, NA-D indicated staff would benefit from additional training related to dementia care and behaviors. On 8/3/22 at 4:35 p.m. interview with nurse manager and director of nursing (DON), DON	F 744		

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F 744	Continued From page 53 confirmed R1 had not been re-assessed to determine appropriate interventions for increased physical behaviors and R1's care plan had not been updated since 2019, as well as the care guide sheet as of 8/3/22, had no safety interventions for R1's behaviors. In addition, DON stated the interdisciplinary team (IDT) reviews the ACP visit notes at the facility's weekly behavior meetings and implement the recommendations. DON confirmed R1's medical record lacked evidence a medication review was completed as recommended by ACP on 7/6/22. Review of facility policy titled Care Plans-Comprehensive, not dated, indicated the resident's comprehensive care plan is developed within seven days of the completion of the resident's MDS. Further, care plan indicated identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require data gathering, proper sequencing or events and complex decision making. Review of facility policy titled Behavioral Assessment, Intervention and Monitoring, not dated, indicated the interdisciplinary team (IDT) will thoroughly evaluate new or changing behavioral symptoms to identify underlying causes and address any modifiable factors that may have been contributed to the resident's change in condition. The IDT will evaluate behavioral symptoms in residents to determine the degree, severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. Further review of policy	F 744		

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F 744	Continued From page 54 indicated the care plan will include targeted and individualized interventions for the behavioral symptoms and how the staff will monitor for effectiveness of the interventions. Interventions will be adjusted based on the impact on behavior.	F 744		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		9/3/22

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F 756	Continued From page 55 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were acted upon, addressed, and documented in the medical record for 5 of 5 residents (R2, R5, R4, R1, R8) who received recommendations from the pharmacist. Findings include: R2, R5, R4, R1, and R8's Omnicare of Minnesota Consultation [pharmacy] Reports were requested and provided by the facility after medical record review identified the medical records lacked the pharmacy reports. The medical records and provided printed reports identified the following: R2's quarterly Minimum Data Set (MDS), dated 7/6/22, identified R2 was diagnosed with an anxiety disorder and dementia and received antianxiety medication seven days a week. R2's face sheet, printed 8/9/22, indicated her dementia was with behavioral disturbances. R2's Consultation Report, dated 3/4/22, indicated her medication regimen was reviewed by the CP and identified she had two orders for clonazepam (anti-anxiety medication) which when combined appeared she was ordered to take 0.25mg three times a day if the once a day and twice a day orders were combined. The report recommended	F 756	F756 1. Immediate action(s) taken for the identified problem include: R2, R5, R4, R1, R8 had their recommendations reviewed by the providers. Changes were implemented with the providers input. DON has communicated with all physicians to stress the importance of returning drug regimen reviews. Any reviews from August not returned from the physician by 8/31/2022 will be given to the medical director to review and sign off. 2. Identification of similar occurrences of the problem was accomplished by: All residents have the potential to be affected by this type of situation. All residents medication regimens are being reviewed by the facility's consultant pharmacist. 3. Actions taken/systemic changes put into place to ensure deficient practice will not recur: The facility changed pharmacy vendor and reviewed internal processes for efficiency and efficacy. The DON and/or designee will review policies and procedures for pharmacy reviews and	

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F 756	Continued From page 56 to clarify and update the medication administration record accordingly. The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature. R2's medical record was reviewed and showed evidence she was ordered, on 3/3/22, clonazepam 0.25mg twice a day "AND" 0.25mg once a day for anxiety [combined dosages equaled 0.25mg three times a day]. Her March MAR identified an order, initiated 3/4/22, for clonazepam 0.25mg twice a day and lacked the 3/3/33 ordered 0.25mg once a day dosage. Her order summary, reviewed 8/9/22, continued to direct staff to administer the twice a day dosing only. R2's medical record lacked evidence the CP's recommendation for clarification was forwarded, reviewed, and/or acted upon by the physician and/or staff despite the recommendation being made over five months ago or that the physician, from 3/4/22 through 8/9/22, discontinued the 0.25mg once a day order. R5's quarterly MDS, dated 6/24/22, identified R5 was diagnosed with chronic pain and was not administered opioid medication during the review period. R5's Consultation Report, dated 6/1/22, indicated his medication regimen was reviewed by the CP and identified R5 was ordered oxycodone (narcotic pain medication) 5mg PRN that was not administered in over 60 days. The report recommended the PRN oxycodone be discontinued due to non-use. The report continued and provided an area for the physician and DONs responses/signatures. The report	F 756	irregularities. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The DON and/or designee will follow-up within 14 days of initial request sent to physician to ensure completion. If no completion, a second request will be sent to the physician. If still no response, request will be sent to Medical Director for review and completion. Nursing recommendations will be addressed by the DON or designee with in 14 days of receipt. Corrective action completion date: 9/3/2022	

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F 756	Continued From page 57 lacked a physician's or DONs response and both signatures. R5's medical record was reviewed and lacked evidence the CP's recommendations on R5's PRN oxycodone was forwarded, reviewed, and/or acted upon by the physician despite the recommendation being made approximately two months prior and R5's June through August MAR's continued to show an active order for PRN oxycodone with no record it was administered. R4's significant change MDS, dated 7/20/22, identified R4 was diagnosed with a thyroid disorder, anxiety and depression. R4's Consultation Report, dated 6/1/22, indicated her medication regimen was reviewed by the CP and identified she was ordered lorazepam (anti-anxiety medication) 1mg TID (three times a day) PRN for anxiety. The report recommended if the medication could not be discontinued, current regulation required the prescriber to document the indication of use, the intended duration of therapy (a stop date), and the rationale for the extended time period. The report continued and provided an area for the physician and director of nursing responses/signatures. The report lacked a physician's response and both signatures. A subsequent Consultation Report, dated 7/6/22, identified R4 received a thyroid replacement medication; however, a recent TSH lab was not located in her medical record. The CP recommended to monitor a TSH level on the next convenient lab day. The report continued and provided an area for a physician response and associated physician and DON signature sections. The report lacked a provider and DON	F 756		

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F 756	Continued From page 58 response/signatures. R4's medical record was reviewed and lacked evidence the CP's recommendation for lorazepam review and a TSH level were forwarded, reviewed and/or acted upon by the physician despite the recommendations being made over 60 and 30 days respectively and she was ordered and/or received the dosing of the medications which were identified needed review and TSH monitoring. R1's annual MDS, dated 6/6/22, identified R1 was diagnosed with dementia and depression and received antipsychotic medication seven days a week. R1's face sheet, printed 8/9/22, indicated her dementia was with behavioral disturbances. R1's Consultation Report, dated 6/2/22, indicated her medication regimen was reviewed by the consulting pharmacist (CP) and was identified she received an antipsychotic medication. The report recommended R1's orthostatic blood pressures (BP) were routinely monitored. The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature. A subsequent Consultation Report, dated 6/2/22, indicated R1 was ordered quetiapine (antipsychotic medication) 12.5mg (milligrams) every 6 hours PRN (as needed) for anxiety/restlessness which was in place for greater than 14 days without a stop date. The report identified CMS (Centers for Medicare and Medicaid) required PRN orders for antipsychotic medications to be limited to 14 days. A new order was not to be written without the resident being directly examined by the prescriber who	F 756		

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F 756	Continued From page 59 personally assessed the resident's condition and progress to determine if the PRN antipsychotic was still needed. The report recommended to discontinue the PRN order or add a 14 day stop date and recommended the addition of a supporting diagnosis. The report continued and provided an area for the physician and director of nursing responses/signatures. The report lacked a physician's response and both signatures. R1's medical record was reviewed and lacked evidence orthostatic BPs were initiated per a physician or nursing order or that R1 refused orthostatic BP check attempts. In addition, her medical record lacked evidence the PRN quetiapine recommendation report was forwarded, reviewed and/or acted upon by the physician despite the recommendation being made over 2 months prior and R1's Order Summary Report, printed 8/9/22, indicated a PRN quetiapine order, dated 5/9/22, provided a diagnosis of restlessness/anxiety and lacked a stop date. R8's admission MDS, dated 6/17/22, identified R8 was diagnosed with gastroesophageal reflux disease (GERD) and constipation. R8's Consultation Report, dated 6/13/22, indicated on admission he was ordered senna-docusate 8.6-50mg 2 tabs twice a day (BID) PRN for constipation; however, the PRN was not listed on the June MAR. The report recommended staff clarified the medication order or added the PRN order to the MAR if the order remained current. The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature.	F 756		

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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 756	Continued From page 60 A subsequent Consultation Report, dated 7/6/22, identified R8 received ibuprofen (nonsteroidal anti-inflammatory medication) 600mg every day (QD) in which administration with food and adequate fluid could minimize gastrointestinal (GI) distress. The report recommended to ensure the ibuprofen was administered at meal time or with food and adequate fluid (4 to 8 ounces). The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature. R8's medical record was reviewed and lacked evidence the CP's recommendations on R8's PRN senna-docusate or ibuprofen administration were either addressed by the DON or forwarded, reviewed, and/or acted upon by the physician despite the recommendation being made approximately two and one months respectively prior and R8 continued to receive ibuprofen QD. During a telephone interview on 8/9/22, at 10:55 a.m. the CP stated, effective 7/31/22, Omnicare no longer provided consulting pharmacy services to the facility. She explained after she completed her monthly medication reviews, she emailed the reviews to the DON and expected the DON to distribute the reviews/recommendations to the providers or nurse managers. Further, she expected the reviews/recommendations to be addressed with the next routine physician visit or by the review's recommended date. If the facility followed this time frame expectation, the completed reviews and addressed recommendations would then be available for her follow up review with her next visit, which she stated was part of her review process. She explained indication(s) of provider or facility	F 756		

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	245289	A. BUILDING _____ B. WING _____	C 08/09/2022

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F 756	Continued From page 61 review would be identified on the review with a provider and/or DON response and signature. The CP indicated she participated in the facility's quality assurance (QAPI) committee process. She stated, from 2/1/22 through 4/30/22, the facility's 30 day response/completed rate was 85 percent (%) and their 60 day rate was 89%. She indicated "it [rate] was pretty good." She stated she lacked any overall concerns with the facility's process for the reviews; however, she identified there were times when her prior reviews were not yet scanned into the medical record for her review. When interviewed on 8/9/22, at 11:49 a.m. nurse manager (LPN)-B stated he "occasionally" reviewed CP recommendations "when they come to my knowledge;" however, most of the time the DON followed up with the reviews and he was "not too sure" if he addressed any of the recommendations since he started his position approximately two months ago. He acknowledged the reviews were sent to him and the DON via email. He explained the importance of timely completed pharmacy recommendations was related to patient safety and correctly administered medications. If the reviews were not addressed timely, a resident could experience adverse effects and "the sole purpose of that medication will not be met." He denied knowledge the facility experienced any concerns with the review/recommendation process. During interview on 8/9/22, at 1:39 p.m. the DON stated after her hire date in April, she started to receive emailed CP reviews in May which she passed them on to where she felt they needed to go (psychiatrist, physician box, etc.) for review and follow-up. She stated "some" of the reviews	F 756		

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F 756	Continued From page 62 were returned and stated further, today (8/9/22), social services informed her the psychiatrist was not addressing the reviews/recommendations and just kept them for their records. She was unsure as to what the other providers were doing with their reviews or where they were going once addressed. The DON acknowledged audits were not performed to ensure the reviews were addressed, returned, and scanned into the residents' medical records and stated she needed to have conversations with the providers to start working on the review process. She reported there was a significant back log of scanning that needed to be completed and explained she was informed, "Paperwork is not life and death and thus not really important." She stated the scanning needed to be completed; however, the facility had patients to take care of. The DON stated, "If there is not a progress note [in the resident's medical record] that I worked on it, it was not touched [completed]." She verbalized CP reviews/recommendations were important "for the betterment of the patient" and risk factors related to an incomplete process "depends on the recommendation." A consulting pharmacist policy was requested. An Omnicare, A CVS Health company policy, 9.0 Pharmacy Consultant Services, revised 4/1/17, was provided and identified the policy lacked directives for the CP and/or for the facility related to the CP recommendation review process. A policy for the current consulting pharmacy medication review services was not provided.	F 756		

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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 8/1/22 through 8/9/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H52893729C (MN85651, MN85680, MN85664), with licensing orders issued at 0900 and 1530, H52893549C (MN85410) and H52893242C (MN85016) with no licensing order issued. The following complaints were found to be UNSUBSTANTIATED: H52893516C (MN85419), H52893658C (MN85560). 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	2 000		

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2 000	Continued From page 2 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 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		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		9/3/22

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2 900	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents identified at risk for worsening pressure ulcers received the necessary care and treatment to decrease the risk of worsening wounds and decreased healing for 1 of 1 residents (R7) who in the sample of residents was identified to have a pressure ulcer and who followed the rounding wound care physician. Findings include: R7's hospital History and Physical, dated 12/3/21, identified R7 presented to the hospital with a sacral decubitus (pressure) ulcer. R7's quarterly Minimum Data Set (MDS), dated 7/8/22, identified R7 was severely cognitive impaired and was free of exhibited rejection of care(s). She required extensive physical assist for mobility and cares and experienced total bladder and bowel incontinence. Diagnosis included dementia, morbid obesity, weakness, and a sacral region pressure ulcer. In addition, the MDS identified R7 was at risk for pressure ulcers based on formalized and clinical assessments in which R7 presented with a stage 4 pressure ulcer and pressure ulcer care. R7's Care Plan, printed 8/9/22, identified R7 was dependent on staff for " ...intellectual, physical ...needs r/t (related to) cognitive deficits, immobility, and physical limitations. Her ADL (activities of daily living) care needs directed staff to use extensive assistance to assist R7 to turn and reposition in bed and her Care Plan identified R7 presented with a stage 4 pressure ulcer on her coccyx r/t immobility. Interventions included	2 900	Corrected	

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2 900	Continued From page 4 the following: administer treatments as ordered and monitor for effectiveness, avoid positioning on coccyx for extended periods of time, encourage and assist to shift weight in wheelchair every 15 minutes, if treatments refused, confer with her, IDT (interdisciplinary team), and family to determine why and to try alternative methods, assist to turn/reposition at least every two hours, more often as needed or requested. Vohra Wound Physicians Initial Wound Evaluation and Management Summary, dated 1/4/22, identified R7 was examined to have a stage 4 sacral pressure ulcer (6cm (centimiters -length) x 5cm (width) x 3cm (depth); 30cm surface area (length x width); 10% slough (dead tissue); 90% granulation (signs of healing tissue). Initial provider orders were as follows: -Leptospermum Honey [Medihoney] BID (twice a day) applied to the wound base. -Alginate Calcium (dressing) BID -Gauze Roll (Kerlix) BID - pack remainder of wound with fluffed Kerlix and cover with a foam border dressing. R7's MAR/TAR (medication/treatment administration record(s) dated 1/4/22 - 4/19/22, lacked evidence staff were directed to pack the wound with "fluffed" Kerlix. In addition, her MAR/TAR dated 1/4/22 - 4/19/22, indicated a PRN (as needed) order for coccyx wound dressing changes; however, the orders from 1/4/22 - 8/4/22 lack evidence of a PRN order. Subsequent Vohra visits identified the following information: -1/18/22: the wound progress improved. During the visit she was initially evaluated to have diagnosis of lichenification and "Moisturizer to areas of dry skin daily" was ordered. R7's MAR/TAR dated 1/18/22 - 8/4/22, lacked	2 900		

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2 900	Continued From page 5 evidence the moisturizer order was initiated. -1/25/22: the wound progress remained unchanged (5cm x 4cm x 2cm; 20cm surface area with undermining 1.5cm at three o'clock, 5% necrotic (hard dead tissue); 5% slough (dead tissue) 90% granulation). A "purplish discoloration of left side of wound bed" was observed and the provider recommended "[R7] to rest more on right side to alleviate pressure on left side of wound." R7's MAR/TAR dated 1/25/22 - 8/4/22, directed staff to turn and reposition R7 every two hours and lacked evidence of the order to rest more on her right side. -3/10/22: the wound progress deteriorated (5cm x 4cm x 3cm; 10cm surface area; 60% granulation; 40% "other viable tissues" 40% muscle) "due to patient non-compliant with wound care." The provider recommended "limit sitting to one hour up in chair or wheelchair, then one hour of resting on side." R7's MAR/TAR dated 3/10/22 - 8/4/22, lacked evidence the order was initiated. -4/5/22: the wound progress improved. -4/19/22: the wound progress remained unchanged (4cm x 3cm x 2cm; 12cm surface area; 20% slough; 40% granulation; 40% muscle); however, an order was provided for Santyl (enzymatic debriding agent) once a day (QD) to be applied to the wound after the wound was cleansed with wound cleanser. The Alginate Calcium order continued for BID. The honey application was discontinued. R7's MAR/TAR dated 4/19/22 - 8/4/22 directed staff to apply Santyl after the wound was cleansed and then to cover with calcium alginate, pack with Kerlix, and cover with an ABD (high absorbency) dressing and tape BID; however, the MAR/TAR lacked evidence of the once a day Santyl application was initiated. In addition, R7's medical record/wound care orders continued to direct a foam border dressing and she lacked an order for ABD	2 900		

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2 900	Continued From page 6 dressing and tape. Furthermore, the MAR/TAR indicated the Medihoney order ended on 4/22/22, not as ordered on 4/19/22. -4/26/22: the wound progress deteriorated (5cm x 2.7cm x 2cm; 13.5cm surface area; 60% slough; 20% granulation; 20% muscle) and the Alginate Calcium, Kerlix, and foam border dressing order was changed to an QD application (the BID order was discontinued). An Additional Wound Detail note indicated the "DON will review dressing application with nursing." R7's MAR/TAR dated 4/26/22 - 8/4/22, directed BID wound care dressing changes and lacked evidence the order was changed to QD. -5/3/22: the wound progress remained unchanged. An Additional Wound Detail note indicated "Application of Santyl demonstrated to nursing." -5/17/22: the wound progress improved (4.5cm x 3.7cm x 2cm; 16.65cm surface area; continued undermining; 30% slough; 50% granulation; 20% muscle; however, an order for house barrier cream to be applied around the wound perimeter QD was provided. R7's MAR/TAR dated 5/17/22 - 8/4/22 lacked evidence of a barrier cream order. -6/7/22: the wound progress deteriorated (5.9cm x 4.7cm x 1.5cm; 27.73cm surface area; continued undermining; 20% slough; 60% granulation; 20% muscle). -6/14/22: the wound progress improved. On 6/14/22, R7's MAR/TAR was updated and directed staff to utilize skin prep to the wound edges before the ABD was applied. R7's wound care orders or medical record lacked evidence of a skin prep order and/or the use of an ABD. -7/5/22: the wound progress remained unchanged. -7/12/22: the wound progress remained unchanged. Negative pressure wound therapy (VAC) was ordered to be applied three times per	2 900		

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2 900	Continued From page 7 week. The Alginate Calcium, Kerlix, Santyl and foam border were discontinued. R7's MAR/TAR dated 7/12/22, lacked evidence of a VAC order or that the Santyl and dressings were stopped. -7/19/22: the wound progress remained unchanged (4cm x 5.4cm x 1cm; 21.60cm surface area; 1.5cm continued undermining; 20% slough; 60% granulation; 20% muscle. The VAC order continued. An Additional Wound Detail note indicated "Wound VAC not yet available." No additional wound care orders were provided. -7/26/22: the wound progress improved. An Additional Wound Detail note indicated "Wound VAC not yet in place. DON has been asked to facilitate." No additional wound care orders were provided. -8/2/22: the wound progress improved (5cm x 3.7cm x 1cm; 18.50cm surface area; 1.5cm continued undermining; 10% slough; 70% granulation; 20% muscle). An Additional Wound Detail note indicated "[R7] did not tolerate wound VAC. Periwound erythema developed with VAC. Tx (treatment) now with barrier cream." VAC orders continued; however, Alginate Calcium, Santyl, and a superabsorbent silicone border dressing once a day was ordered. R7's MAR/TAR dated 8/2/22 - 8/4/22 lacked evidence of the new order or the barrier cream. From 7/12/22 - 8/4/22, R7's MAR/TAR lacked evidence the VAC was initiated and continued to direct staff to apply Santyl and the dressings BID. Her medical record lacked evidence the wound care physician (WCP) was updated between wound care rounds related to any VAC complications or to question the need for continued dressing order(s) until the VAC could be initiated. R7's progress notes identified the following	2 900		

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2 900	Continued From page 8 entries: -5/10/22: "[R7] seen by Wound Dr and noted that incorrect alginate being used with Santyl. Licensed staff and Writer [DON] replaced incorrect treatment dressing in designated wound bucket ..." -5/10/22: "[DON] has updated wound treatment to include the following: calcium should not be cut and box removed from should be green. If not in wound supplies in [R7's] room alert DON and/or facility leadership prior to completing dressing change." -From 7/12/22 - 7/28/22, R7's progress notes lacked evidence a VAC was discussed with R7 or family, was ordered, was applied, and/or a rationalization as to why the VAC order was not initiated on 7/12/22 with initial order or on 7/19/22 and 7/26/22 with the continued VAC orders. In addition, the progress notes lacked evidence the wound care provider was updated related to the VAC directed orders not being initiated or performed. -7/29/22 (a late entry recorded on 8/3/22): "A wound VAC was applied as per the wound doctor order. Resident initially complained of the wound vac being uncomfortable. Resident will continue to be monitored and subsequent changes will be to provide resident more comfort." -From 7/29/22 - 8/2/22: R7's progress note lacked documentation related to the VAC. -8/3/22: "her bottom is red in patches some from the tape removal. The wound edges are whitish and the skin is pealing [sic] off in some areas. [R7] has an order for negative pressure therapy but the wound vac is missing, and so the writer did Santyl and silver alginate and ABD was used, the DON, nurse manager and family were notified. The management will call the wound doc for new orders till the wound vac issue is resolved. In coming nurse was updated." [on	2 900		

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2 900	Continued From page 9 8/2/22 wound care provider was updated (per her dictation) that R7 did not tolerate the VAC and she provided new orders for Alginate Calcium, Santyl and a superabsorbent silicone border dressing QD]. -From 8/3/22 - 8/9/22, R7's progress notes lack evidence the wound care provider was updated related to R7's 8/3/22 progress note and/or to obtain an order to officially discontinue the 8/2/22 continued VAC order. -8/4/22: "[DON has reached out to Custom Medical regarding the following inquiry: Was wound vac picked up not showing up in here to reflect she has one here. It has been discontinued by the Dr per family request; response pending." -From 8/4/22 - 8/9/22, R7's progress notes lacked evidence the VAC was found or discontinued. When interviewed on 8/4/22, at 3:15 p.m. LPN-E stated she was responsible for processing orders and explained either the health unit coordinator (HUC) or a nurse initially processed the order and then a nurse was required to double check it. She stated once staff completed the order process, they were required to sign the order to verify it was completed. LPN-E denied she processed orders from the WCP and was unsure as to the orders process when the WCP completed wound rounds on Tuesdays. She confirmed nurses were expected to follow what the MAR/TAR directed and if there were concerns, they were expected to update the provider for clarification. LPN-E acknowledged a first floor resident recently received VAC treatment; however, she was unaware of any residents on other floors that received recent VAC orders. She stated R7 required a dressing change every evening. She was unsure as to what R7's day shift orders were. She stated she was unaware R7 was recently	2 900		

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2 900	Continued From page 10 ordered to try a VAC and R7 was ordered for every two hour repositioning. LPN-E explained R7 propelled herself around the unit with her wheelchair and was compliant with the every two hour repositioning; however, she commented R7 was often in her wheelchair during the evening shift and staff attempted to encourage her to lay down right after supper: "If she is ready." She denied R7 took naps or laid in bed during the evening shift when she worked. During a telephone interview on 8/5/22, at 8:46 a.m. WCP stated she provided weekly resident wound care rounds in which rounds consisted typically of the nurse manager (LPN)-B, a nurse if available, and then a nursing assistant (NA) would follow when first floor wound rounds were conducted. She explained staff prepare the residents for her visit in which either she or the staff removed the old dressings. She then examined and assessed the wounds in which LPN-B took notes related to suggested wound care treatment changes and/or recommendations. Once the visit was over, the nurse would complete the ordered treatment. She confirmed she did not review each resident's medical record (progress notes/MAR/TAR) during each visit to review the orders and to ensure her orders were being carried out as she prescribed. She explained that was the facility's responsibility. She stated when she observed "something [dressing] missing" she inquired if the order was on the MAR/TAR. The WCP confirmed she observed "probably one or two patients every week" with incorrectly performed wound care treatments which she stated was "more common if I changed the dressing" the previous visit. She continued there were times when there was "a lag on getting the dressing that I ordered ...I am not sure what happens." She acknowledged there	2 900		

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2 900	Continued From page 11 were also times when she was required to inquire as to the whereabouts of an ordered dressing or the Santyl. She stated "it has been an ongoing process to fix it [supply issues]." She responded she "generally" is not updated on facility issues related to order clarification requests and/or issues related to obtaining ordered treatment supplies. She typically found out about concerns when she returned to the facility the following week. The WCP verbalized she had spoken to the DON about her concerns; however, she had not drilled down to find out the reasons for the concerns: "It would seem there should be a uniform process." When the WCP ordered wound treatments she had specific thoughts in mind and rationalizations as to why she choose, or did not choose, a particular treatment. She explained if a resident was provided wound care treatment(s) she did not order, the treatment error would make it more difficult for her to evaluate and assess the wound: "It slows down the evaluation process" and the wound may show a "failure to progress." The wound may also decline and/or the wound may develop moisture associated skin damage if staff failed to provide a barrier cream. The WCP stated her dictated progress notes, with updated orders, were available to the staff the same day as the wound rounds in which she expected the staff to review the dictation for any order or recommendation adjustments. and/or the need for any clarifications. and then process her orders and recommendations as written. The WCP stated " ...in general they are trying very hard and it seems they need some guidance on the process. It is not just measuring the wounds ...the orders need to be in and done correctly. Supplies need to be in the facility and in the room and they may need some process changes or at least to look at that process." The WCP stated R7's sacral ulcer "kind of plateaued" and she started to	2 900		

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2 900	Continued From page 12 develop slough in the wound so she ordered Santyl. She explained R7 had utilized a VAC upon admission; however, at that time she failed to tolerate the treatment and it was discontinued; however, when R7's wound started to produce less drainage and appeared to be getting smaller in size, with R7 experiencing decreased complaints of wound pain and increased ability to assist with bed mobility, the WCP discussed with R7's husband reapplying the VAC. She explained the VAC was not in place when she returned for wound rounds the following week after she initially ordered it. She stated staff informed her the DON wished to have a conversation with R7's husband as the DON was told by staff he did not want the VAC placed on R7. The WCP asked staff to double check on that information and informed the staff the husband had okayed a trial use of the VAC with her conversation, and if R7 did not tolerate, they would discontinue it. The week following, the WCP did not observe the VAC in place and she stated she was informed the facility did not have the VAC. She explained she emailed the DON and she was informed by facility staff someone was going to order it. With her most recent visit on 8/2/22, she stated staff informed her staff applied the VAC to R7; however, "she did not tolerate it." The WCP confirmed she did not review R7's medical record after she ordered the VAC to determine if her orders for R7 were followed. She explained, "I would have a low bar for making [R7] use [the VAC] but I thought she might be fine if they bridged it ...her wound has stalled out and it is a deeper wound, and a wound that if we had this, someone would put a VAC on it to bring it together." Further, she explained she ordered the VAC as R7's husband indicated he was attempting to discharge R7 to another facility to be closer to him and she felt this would help	2 900		

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2 900	Continued From page 13 facilitate such a move as the treatment would only be three times a week, not daily. The WCP, when questioned on her expectations for recommendations, confirmed the recommendations were to be treated as orders and were to be processed as such. She confirmed her recommendation for R7's hourly repositioning should be in her orders and in her care plan. If R7 declined the recommendation as ordered, she expected to see progress notes which indicated the refusals and that she were updated. If repositioning recommendations were not followed, she explained the wound could get larger and deeper. She stated, " ...maybe it [R7's wound] would have gotten smaller faster if they would have followed that order." During interview on 8/5/22, at 2:05 p.m. LPN-C stated when an order was received the health unit coordinator (HUC) initially entered the order into the MAR/TAR. After, a nurse performed a double check. LPN-C explained wound care provider orders were processed "like any other doctor." He confirmed orders were expected to be processed exactly how the order was wrote by the provider and the order was expected to be followed. LPN-C stated if orders were not processed or followed risks to the residents may occur: "It would depend on what the error was." He provided a verbal example in which during dressing changes he had personally observed an "ABD" or a "Mepilex" on a resident; however, upon his review of the MAR/TAR, these types of dressings were not the active order. LPN-C explained if the wrong dressing or treatment was observed, he reviewed the MAR/TAR and it was not his overall practice to review the actual provider order. LPN-C acknowledged discussions with the nurse manager about such concerns and other medication order process concerns and	2 900		

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2 900	Continued From page 14 verbalized he was not involved in the weekly wound round process. When interviewed on 8/5/22, at 2:50 p.m. the evening nurse supervisor (LPN)-D stated when she received orders or order changes she processed them and then the order was double checked by another nurse. She expected the order to be processed as wrote and if the nurse questioned the order the provider was to be updated for clarifications. Further, she expected the nurses to follow the orders as prescribed. She explained, if a wound care order was not followed as prescribed, "That might cause the wound to deteriorate." She confirmed she was unaware of any current concerns related to staff not following provider orders or nurses finding non-ordered dressings on residents. Further, she confirmed she was not aware of any wound treatment supply issues. She denied knowledge of any residents recently being ordered a VAC and/or issues obtaining a VAC if one were ordered. She acknowledged if a VAC order was not processed, for any reason, the provider was to be updated for additional orders until the VAC situation was fixed. During a telephone interview on 8/9/22, at 10:24 a.m. R7's family member (FM)-A stated he had issues with R7's wound care. He explained staff do not follow the physician orders and reported he had observed her wound to be "open" and no dressings in place. He acknowledged this happened "maybe three times in the seven months she has been there." He verbalized this concern improved after the last time and his conversation with the WCP when he updated her on his concerns and she informed him she would talk to someone; however, he expressed his frustration related to R7's recent VAC order. He	2 900		

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2 900	Continued From page 15 explained he conversed with the WCP "the last three weeks" related to the VAC and he confirmed he initially agreed for R7 to attempt the VAC again "for a little while to see if it can get it to close a little quicker" and if R7 did not tolerate it, the VAC would be discontinued. FM-A stated he visited R7 at a minimum three days a week and he confirmed he did not observe the VAC on R7's wound and further confirmed the staff did not talk with him about any attempted application of the VAC and/or if they did how R7 tolerated it. When interviewed on 8/9/22, at 11:49 a.m. LPN-B stated he started the nurse manager role in May (approximately two months prior). He explained during wound rounds he took notes based on comments provided by the WCP, and once the WCP completed her dictated reports, he reviewed them and ensured the orders in the MAR/TAR were updated and/or current. He explained he or the nurses could process the WCP orders and stated he expected the order for the WCP and the order entered into the MAR/TAR were exact. He confirmed all orders were expected to be double checked and co-signed on the order sheet and then the HUC would scan the order into the medical record. LPN-B stated the WCP did not send "regular" orders and "they just get scanned in." He confirmed he did not co-sign the WCP orders or that he asked another nurse to double check the orders; however, if another nurse was to process the WCP orders, he expected them to have another nurse co-sign them. He stated processing and following the WCP orders were expected and were important to help minimize the risk of the wound "getting out of hand" such as infection or decreased healing. He acknowledged he printed out the orders and went through them one at a time to check them for accuracy and	2 900		

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2 900	Continued From page 16 indicated it was "a lot for one person." In addition, he acknowledged he lacked any observations the wrong dressings or treatments were provided to residents. He confirmed the facility experienced no recent order supply concerns. LPN-B stated, on 7/29/22, he initially applied the VAC to R7 and then on 7/30/22 he reapplied it as R7 "messed with it." He confirmed these were the only two days R7 utilized the VAC per his knowledge. He indicated staff found the VAC that morning (8/9/22) after it was reported missing. LPN-B explained R7's family was "indecisive" with the initial VAC order and once R7's husband agreed to the treatment, they ordered the VAC. When questioned why R7's MAR/TAR lacked the VAC order, after his review of her orders, he expressed he was unsure and confirmed the order was not processed. In addition, he acknowledged the VAC order was expected to be in her MAR/TAR, along with any documentation related to the VAC placement, R7's reaction to the VAC, and reason for its discontinuation. LPN-B stated R7 was not a resident who tampered with her dressings and her husband was often her to help keep an eye on her so she did not. He identified R7 was to be turned and repositioned every two hours and he commented, "Most of the time she is out and about with her husband and in the wheelchair." He acknowledged, after review of the WCP recommendations for repositioning, that R7 should have an order for the hourly repositioning. He verbalized increased repositioning for R7 may have assisted in promoting healing and there was a risk of delayed healing for R7 as she was not repositioned per the WCP recommendations. During interview on 8/9/22, at 1:39 p.m. the DON stated the WCP dictated notes and orders did not come the traditional way as other provider orders	2 900		

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2 900	Continued From page 17 were received. She confirmed the WCP dictation and orders were available for review within 24 hours in which nurse management and leadership was responsible to make sure the orders were updated, current, and processed as wrote by the WCP. In addition, she expected staff to follow the order as prescribed and if there were concerns identified with the order, the provider was to be contacted for clarification. The DON stated if staff failed to follow an order as prescribed staff were not doing what they were expected to do, which could cause a wound infection. The DON confirmed there were issues with R7's VAC order being implemented, mainly related to concerns with facility, family, and WCP conversations not aligning. She stated R7's VAC orders should have been processed when it was originally ordered and confirmed she had not yet followed up with LPN-B related to her documentation and order processing concerns related to R7. A policy for physician order processing and transcription was requested. An undated policy Medication and Treatment Orders was provided and identified the policy's purpose was for medication and treatment orders to be consistent with principles of safe and effective order writing. The policy identified drug and biological orders were to be recorded on the Physician's Order Sheet in the resident's chart. The policy lacked direction on the facility's process for nurse order processing and transcription or expectations related to medication and/or treatment administration. An undated policy Wound Care identified the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The policy directed staff to verify the	2 900		

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2 900	Continued From page 18 physician order prior to the treatment and document specific information in the resident's medical record after completion i.e. type of wound care provided, any changes in the resident's condition, all assessment data obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints reported, and if the resident refused the treatment and the reason why. In addition, the policy directed to notify the supervisor if the resident refused the wound care and to report other information in accordance with facility policy and professional standards of practice. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers and/or non pressure related skin impairments to assure they are receiving the necessary treatment/services to prevent skin impairments from developing and to promote healing. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for skin impairments. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be	21530		9/3/22

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21530	Continued From page 19 reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were acted upon, addressed, and documented in the medical record for 5 of 5 residents (R2, R5, R4, R1, R8) who received recommendations from the pharmacist. Findings include: R2, R5, R4, R1, and R8's Omnicare of Minnesota Consultation [pharmacy] Reports were requested and provided by the facility after medical record review identified the medical records lacked the pharmacy reports. The medical records and provided printed reports identified the following: R2's quarterly Minimum Data Set (MDS), dated 7/6/22, identified R2 was diagnosed with an anxiety disorder and dementia and received antianxiety medication seven days a week. R2's face sheet, printed 8/9/22, indicated her dementia was with behavioral disturbances. R2's Consultation Report, dated 3/4/22, indicated her medication regimen was reviewed by the CP and identified she had two orders for clonazepam (anti-anxiety medication) which when combined appeared she was ordered to take 0.25mg three times a day if the once a day and twice a day orders were combined. The report recommended to clarify and update the medication administration record accordingly. The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature. R2's medical record was reviewed and showed evidence she was ordered, on 3/3/22,	21530	Corrected	

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21530	Continued From page 21 clonazepam 0.25mg twice a day "AND" 0.25mg once a day for anxiety [combined dosages equaled 0.25mg three times a day]. Her March MAR identified an order, initiated 3/4/22, for clonazepam 0.25mg twice a day and lacked the 3/3/33 ordered 0.25mg once a day dosage. Her order summary, reviewed 8/9/22, continued to direct staff to administer the twice a day dosing only. R2's medical record lacked evidence the CP's recommendation for clarification was forwarded, reviewed, and/or acted upon by the physician and/or staff despite the recommendation being made over five months ago or that the physician, from 3/4/22 through 8/9/22, discontinued the 0.25mg once a day order. R5's quarterly MDS, dated 6/24/22, identified R5 was diagnosed with chronic pain and was not administered opioid medication during the review period. R5's Consultation Report, dated 6/1/22, indicated his medication regimen was reviewed by the CP and identified R5 was ordered oxycodone (narcotic pain medication) 5mg PRN that was not administered in over 60 days. The report recommended the PRN oxycodone be discontinued due to non-use. The report continued and provided an area for the physician and DONs responses/signatures. The report lacked a physician's or DONs response and both signatures. R5's medical record was reviewed and lacked evidence the CP's recommendations on R5's PRN oxycodone was forwarded, reviewed, and/or acted upon by the physician despite the recommendation being made approximately two months prior and R5's June through August	21530		

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21530	Continued From page 22 MAR's continued to show an active order for PRN oxycodone with no record it was administered. R4's significant change MDS, dated 7/20/22, identified R4 was diagnosed with a thyroid disorder, anxiety and depression. R4's Consultation Report, dated 6/1/22, indicated her medication regimen was reviewed by the CP and identified she was ordered lorazepam (anti-anxiety medication) 1mg TID (three times a day) PRN for anxiety. The report recommended if the medication could not be discontinued, current regulation required the prescriber to document the indication of use, the intended duration of therapy (a stop date), and the rationale for the extended time period. The report continued and provided an area for the physician and director of nursing responses/signatures. The report lacked a physician's response and both signatures. A subsequent Consultation Report, dated 7/6/22, identified R4 received a thyroid replacement medication; however, a recent TSH lab was not located in her medical record. The CP recommended to monitor a TSH level on the next convenient lab day. The report continued and provided an area for a physician response and associated physician and DON signature sections. The report lacked a provider and DON response/signatures. R4's medical record was reviewed and lacked evidence the CP's recommendation for lorazepam review and a TSH level were forwarded, reviewed and/or acted upon by the physician despite the recommendations being made over 60 and 30 days respectively and she was ordered and/or received the dosing of the medications which were identified needed review	21530		

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21530	Continued From page 23 and TSH monitoring. R1's annual MDS, dated 6/6/22, identified R1 was diagnosed with dementia and depression and received antipsychotic medication seven days a week. R1's face sheet, printed 8/9/22, indicated her dementia was with behavioral disturbances. R1's Consultation Report, dated 6/2/22, indicated her medication regimen was reviewed by the consulting pharmacist (CP) and was identified she received an antipsychotic medication. The report recommended R1's orthostatic blood pressures (BP) were routinely monitored. The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature. A subsequent Consultation Report, dated 6/2/22, indicated R1 was ordered quetiapine (antipsychotic medication) 12.5mg (milligrams) every 6 hours PRN (as needed) for anxiety/restlessness which was in place for greater than 14 days without a stop date. The report identified CMS (Centers for Medicare and Medicaid) required PRN orders for antipsychotic medications to be limited to 14 days. A new order was not to be written without the resident being directly examined by the prescriber who personally assessed the resident's condition and progress to determine if the PRN antipsychotic was still needed. The report recommended to discontinue the PRN order or add a 14 day stop date and recommended the addition of a supporting diagnosis. The report continued and provided an area for the physician and director of nursing responses/signatures. The report lacked a physician's response and both signatures. R1's medical record was reviewed and lacked	21530		

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21530	Continued From page 24 evidence orthostatic BPs were initiated per a physician or nursing order or that R1 refused orthostatic BP check attempts. In addition, her medical record lacked evidence the PRN quetiapine recommendation report was forwarded, reviewed and/or acted upon by the physician despite the recommendation being made over 2 months prior and R1's Order Summary Report, printed 8/9/22, indicated a PRN quetiapine order, dated 5/9/22, provided a diagnosis of restlessness/anxiety and lacked a stop date. R8's admission MDS, dated 6/17/22, identified R8 was diagnosed with gastroesophageal reflux disease (GERD) and constipation. R8's Consultation Report, dated 6/13/22, indicated on admission he was ordered senna-docusate 8.6-50mg 2 tabs twice a day (BID) PRN for constipation; however, the PRN was not listed on the June MAR. The report recommended staff clarified the medication order or added the PRN order to the MAR if the order remained current. The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature. A subsequent Consultation Report, dated 7/6/22, identified R8 received ibuprofen (nonsteroidal anti-inflammatory medication) 600mg every day (QD) in which administration with food and adequate fluid could minimize gastrointestinal (GI) distress. The report recommended to ensure the ibuprofen was administered at meal time or with food and adequate fluid (4 to 8 ounces). The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature.	21530		

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21530	Continued From page 25 R8's medical record was reviewed and lacked evidence the CP's recommendations on R8's PRN senna-docusate or ibuprofen administration were either addressed by the DON or forwarded, reviewed, and/or acted upon by the physician despite the recommendation being made approximately two and one months respectively prior and R8 continued to receive ibuprofen QD. During a telephone interview on 8/9/22, at 10:55 a.m. the CP stated, effective 7/31/22, Omnicare no longer provided consulting pharmacy services to the facility. She explained after she completed her monthly medication reviews, she emailed the reviews to the DON and expected the DON to distribute the reviews/recommendations to the providers or nurse managers. Further, she expected the reviews/recommendations to be addressed with the next routine physician visit or by the review's recommended date. If the facility followed this time frame expectation, the completed reviews and addressed recommendations would then be available for her follow up review with her next visit, which she stated was part of her review process. She explained indication(s) of provider or facility review would be identified on the review with a provider and/or DON response and signature. The CP indicated she participated in the facility's quality assurance (QAPI) committee process. She stated, from 2/1/22 through 4/30/22, the facility's 30 day response/completed rate was 85 percent (%) and their 60 day rate was 89%. She indicated "it [rate] was pretty good." She stated she lacked any overall concerns with the facility's process for the reviews; however, she identified there were times when her prior reviews were not yet scanned into the medical record for her review.	21530		

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21530	Continued From page 26 When interviewed on 8/9/22, at 11:49 a.m. nurse manager (LPN)-B stated he "occasionally" reviewed CP recommendations "when they come to my knowledge;" however, most of the time the DON followed up with the reviews and he was "not too sure" if he addressed any of the recommendations since he started his position approximately two months ago. He acknowledged the reviews were sent to him and the DON via email. He explained the importance of timely completed pharmacy recommendations was related to patient safety and correctly administered medications. If the reviews were not addressed timely, a resident could experience adverse effects and "the sole purpose of that medication will not be met." He denied knowledge the facility experienced any concerns with the review/recommendation process. During interview on 8/9/22, at 1:39 p.m. the DON stated after her hire date in April, she started to receive emailed CP reviews in May which she passed them on to where she felt they needed to go (psychiatrist, physician box, etc.) for review and follow-up. She stated "some" of the reviews were returned and stated further, today (8/9/22), social services informed her the psychiatrist was not addressing the reviews/recommendations and just kept them for their records. She was unsure as to what the other providers were doing with their reviews or where they were going once addressed. The DON acknowledged audits were not performed to ensure the reviews were addressed, returned, and scanned into the residents' medical records and stated she needed to have conversations with the providers to start working on the review process. She reported there was a significant back log of scanning that needed to be completed and explained she was	21530		

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21530	Continued From page 27 informed, "Paperwork is not life and death and thus not really important." She stated the scanning needed to be completed; however, the facility had patients to take care of. The DON stated, "If there is not a progress note [in the resident's medical record] that I worked on it, it was not touched [completed]." She verbalized CP reviews/recommendations were important "for the betterment of the patient" and risk factors related to an incomplete process "depends on the recommendation." A consulting pharmacist policy was requested. An Omnicare, A CVS Health company policy, 9.0 Pharmacy Consultant Services, revised 4/1/17, was provided and identified the policy lacked directives for the CP and/or for the facility related to the CP recommendation review process. A policy for the current consulting pharmacy medication review services was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		

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{F 000}	INITIAL COMMENTS Surveyor: 43007 On 9/27/22 through 9/29/22, an onsite revisit was conducted to follow up on deficiencies related to a standard abbreviated survey exited 8/9/22. The facility was found to be NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The complaints SUBSTANTIATED: H52893242C (MN85016) and H52893549C (MN85410), with deficiencies previously cited at F600, and deficiencies which were cited at F609 and F756 were reviewed for compliance and were found to be CORRECTED. The complaints SUBSTANTIATED: H52893729C (MN85651, MN85680, MN85664), with deficiencies previously cited at F684, F686, and the additonal cites at F607 and F756 were found NOT to be corrected and remain OUT OF COMPLIANCE. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. 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}		

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

Electronically Signed | 10/20/2022

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

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{F 000}	Continued From page 1	{F 000}		
{F 607} SS=D	Surveyor: 43083 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to develop clear guidelines for protection of residents after allegations of abuse or neglect were made. Findings include: Review of facility policy titled Abuse Investigation and Reporting dated 12/6/21, indicated staff would "protect residents during abuse investigations" however the policy lacked clear guidance on the facility procedure for protection of residents. The policy lacked the following requirements for protection: increased supervision of the alleged victim and residents, room or staffing changes if necessary to protect the residents from the alleged perpetrator,	{F 607}	F607 1. Immediate action(s) taken for the identified problem include: IDT met to discuss the abuse/neglect policy requirements and developed a policy that meets regulatory requirements. 2. Identification of similar occurrences of the problem was accomplished by: All residents have the potential to be affected by this type of situation. 3. Actions taken/systemic changes put into place to ensure deficient practice will not recur: All policies will be reviewed to ensure regulatory requirements are met. Employees will receive training on revised polices for implementation of change. Facility will conduct a facility wide training on the abuse policy	11/4/22

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{F 607}	Continued From page 2 protection from retaliation and providing emotional support and counseling to the resident during the investigation. On 9/28/22, reviewed the facility's Abuse Investigation and Reporting policy dated 12/6/21, the policy lacked evidence of any revisions to provide clear guidance on the facility procedure for protection of residents. Upon interview on 9/28/22, at 1:38 p.m. the assistant administrator stated, the Abuse Investigation and Reporting policy dated 12/6/21, had not been revised and education wasn't completed due to no revisions were completed to educate the facility staff on. Upon interview on 9/28/22, at 1:42 p.m. the administrator stated, "policy on protection was broad in the policy due to every incident was different and you tailor the abuse protection to the residents' needs". Following an incident the interdisciplinary team (IDT) would meet and would determine a plan "tailored towards the incident". Further, administrator indicated the facility's policies were created by corporate who review the regulations. Additionally, the policy would be reviewed by the IDT at the facility when an incident occurs, or the facility needs clarification, the facility would use the policy for guidance. Administrator confirmed the copy of the facility's abuse policy provided to the surveyor was the current policy. Surveyor: 43083	{F 607}	4. Facility will give post test and will continue post testing annually on the abuse policy 5. Administrator or designee will audit employee files to ensure that abuse training is completed 6. Annual revisions of abuse policy will be done through QAPI	
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	{F 684}		10/22/22

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{F 684}	Continued From page 3 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to provide necessary wound care to promote healing and reduce the risk of complications for non-pressure wounds for 2 of 2 residents (R8 and R12) reviewed for wounds. Findings include: R8's admission record identified R8 was admitted in June 2022 with diagnoses of unspecified open wound to lower leg, local infection of the skin and subcutaneous tissue, non-pressure chronic ulcer of the buttock with necrosis of muscle, non-pressure chronic ulcer of the right heel and midfoot with the fat layer exposed, non-pressure chronic ulcer of the left heel and midfoot with necrosis of muscle, and non-pressure chronic ulcer of unspecified lower leg. R8's quarterly Minimum Data Set (MDS) dated 9/17/22, indicated R8 was severely cognitively impaired and required limited assistance of one for dressing, bed mobility, and toileting. R8 was independent with transfers and personal hygiene. In addition, the MDS identified R8 was free of ulcers, wounds, or skin problems; however, R8 continued to be seen by a Vohra wound doctor.	{F 684}	F684 1. Immediate action(s) taken for the identified problem include: Clinical Staff were educated on following wound care orders and the policy on changing and dating wound dressings. 2. Identification of similar occurrences of the problem was accomplished by: R6 care plans were reviewed and updated and all residents with wounds orders will be reviewed and assessed. All residents have the potential to be affected by this type of situation. 3. Actions taken/systemic changes put into place to ensure deficient practice will not recur: Nursing staff to be re-educated on wound care protocols. DON and/or designee will review all residents at risk for pressure ulcers and/or non-pressure related skin impairments to assure they are receiving the necessary treatment/services to prevent skin impairments from developing and to promote healing. Wound supplies available will reflect the di 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Wound round progress notes to be	

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{F 684}	Continued From page 4 R8's care plan dated 8/17/22, indicated R8 had potential/actual impairment to skin integrity related to infection with interventions to: - monitor/document location, size, and treatment of the skin injury -weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, and any other notable changes or observations -report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to medical doctor (MD). The Skin and Wound Evaluation dated 8/30/22, indicated R8 had a surgical wound to the right trochanter measuring 1.3 centimeter (cm) x 0.5 cm and a surgical wound to the dorsum left foot measuring 5.9 cm x 5.0 cm. R8's medical record lacked evidence of any other skin and wound evaluations/assessments. Vohra Wound Physicians Wound Evaluation and Management Summary, dated 8/30/22, indicated R8 was examined to have one wound (full thickness) to the right hip 1.1 cm (length) x 0.5 cm (width) x 0.4 cm (depth); 0.55 cm surface area (length x width); 100 percent (%) granulation (sign of healing) tissue and light serous exudate, one post-surgical wound (full thickness) to the right foot 7.0 cm x 4.7 cm x 0.1 cm; 32.9 cm surface area; 20% slough (dead skin tissue) and 80% granulation tissue with moderate serous exudate, and one post-surgical wound to the left foot 5 cm x 6 cm x 0.1cm; 30 cm surface area; 10% slough, 40% granulation tissue, and 50% other viable tissue (dermis) with moderate serous exudate.	{F 684}	audited by DON and/or designee to monitor for accuracy. The DON and/or designee will conduct measurable audits twice a week for 4 weeks or until substantial compliance is met of the delivery of care to residents affected to ensure appropriate care and services are implemented and reduce the risk for skin impairments. Any issues will be reported immediately for correction, and to QAPI. Corrective action completion date: 9/3/2022	

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{F 684}	Continued From page 5 R8's medical record lacked evidence of wound evaluations on 9/6/22 and 9/13/22. Vohra Wound Physicians Wound Evaluation and Management Summary, dated 9/19/22, indicated R8 was examined to have one wound (full thickness) to the right hip 1.1 cm x 0.8 cm x 0.4 cm; 0.88 cm surface area; 90% slough and 10% other viable tissue (muscle) and moderate serous exudate; "wound progression had deteriorated"; one post-surgical wound (full thickness) to the right foot 6.3 cm x 14.4 cm x 0.3 cm; 90.72 cm surface area; 70% thick adherent vitalized necrotic tissue, 20% slough and 10% other viable tissue (muscle) with moderate serous exudate; "wound progression had deteriorated"; and one post-surgical wound to the left foot 4.7 cm x 7.1 cm x 0.1cm; 33.37 cm surface area; 70% thick adherent vitalized necrotic tissue, 20% granulation tissue, and 10% other viable tissue (dermis, muscle, and subcutaneous) with moderate serous exudate; "wound progression had deteriorated". R8 refused observation of wound care. R12's admission record reviewed on 9/28/22, indicated R12 admitted in July 2022 with diagnosis of cellulitis of right and left lower legs, type II diabetes, and chronic kidney disease. R12's quarterly Minimum Data Set (MDS) dated 8/30/22, indicated R12 was cognitively intact and was independent with activities of daily living (ADL). The MDS further indicated R12 had two venous/arterial ulcers. R12's care plan dated 8/25/22, indicated R8 had potential/actual impairment to skin integrity	{F 684}		

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{F 684}	Continued From page 6 related to fragile skin, diabetes, and chronic wounds with interventions to: - follow facility protocol for treatment of injury; - keep skin clean and dry; -encourage good nutrition. The care plan lacked evidence of intervention to monitor/document location, size, and treatment of the skin injury and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, and any other notable changes or observations. The Skin and Wound Evaluation dated 8/30/22, indicated R12 had a venous ulcer to the left lateral calf measuring 1.6 cm x 0.8 cm and an open lesion to the right lateral calf measuring 4.8 cm x 1.3 cm. R12's medical record lacked evidence of any other skin and wound evaluations/assessments. Vohra Wound Physicians Wound Evaluation and Management Summary, dated 8/30/22, indicated R12 was examined to have venous ulcer (full thickness) of the left leg 1.5 cm x 0.8 cm; 1.20 cm surface area; 10% granulation tissue, 10% slough, 80% skin with light serous exudate, and a venous ulcer (full thickness) of the right leg 4.8 cm x 1.2 cm x 0.1 cm; 5.76 cm surface area; 90% skin with moderate serous exudate. R12's medical record lacked evidence of wound evaluations on 9/6/22 and 9/13/22. R12 refused observation of the wounds. Vohra Wound Physicians Wound Evaluation and Management Summary, dated 9/19/22, indicated R12 was not examined/evaluated due to the visit being rescheduled.	{F 684}		

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{F 684}	Continued From page 7 Interview on 9/29/22, at 11:02 a.m. with the Vohra wound doctor (MD)-H stated the first day of wound assessments he completed were on 9/19/22 in the month of September 2022 to complete the wound assessments. He was made aware there wasn't a nurse to do rounds with him so the wound assessments did not get completed between 8/30/22 to 9/19/22. He was not familiar with the facility and was covering for the routine physician. Upon interview on 9/29/22, at 11:10 a.m. the licensed practical nurse manager (LPN)-A stated all wounds should be assessed every week to prevent worsening of the wound and/or infections. LPN-A verified the wounds had not been assessed weekly per protocol. An undated policy Wound Care identified the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The policy directed staff to verify the physician order prior to the treatment and document specific information in the resident's medical record after completion i.e. type of wound care provided, any changes in the resident's condition, all assessment data obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints reported, and if the resident refused the treatment and the reason why. In addition, the policy directed to notify the supervisor if the resident refused the wound care and to report other information in accordance with facility policy and professional standards of practice. Surveyor: 43080 Surveyor: 43083	{F 684}		

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{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to ensure residents identified at risk for worsening pressure ulcers received the necessary monitoring and assessments to decrease the risk of worsening wounds and decreased healing for 2 of 2 residents (R13 and R14) with pressure ulcers. Findings include: R13's admission record identified R13 was admitted to the faciity in May 2019 with a previous history of a Stage II pressure ulcer (Partial-thickness loss of skin with exposed dermis) to the sacral (lower back) region, a Stage I pressure ulcer (Intact skin reddened skin) of the right heel, and an unstageable pressure ulcer (Full-thickness skin and tissue loss) of the left heel.	{F 686}	1. R13, R14 skin assessments were completed and any skin alterations addressed 2. All residents will have a Braden Assessment complete and any skin alterations addressed 3. Nursing staff will be educated on how to complete a Braden Assessment. Facility will conduct monthly Braden Assessments on residents 4. Skin assessments will be completed weekly on the residents bath day 5. Orders will be placed in PCC for weekly skin checks 6. Schedule created for weekly skin checks. 7. DON or designee will audit skin assessments weekly for 6 weeks 8. IDT will monitor audit during QAPI	11/4/22

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{F 686}	Continued From page 9 R13's quarterly Minimum Data Set (MDS), dated 9/1/22, indicated R13 was cognitively intact and was free of exhibited rejection of care(s). R13 required extensive physical assist of two persons for bed mobility, transfers, dressing, personal hygiene, and toilet use. R13 was at risk for pressure ulcers and required pressure ulcer care. R13's care plan dated 5/3/22, indicated R13 had a Stage II pressure ulcer of the left posterior thigh related to moisture with an intervention for weekly documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate with the Vohra wound doctor. The care plan lacked evidence of documentation of the Stage III pressure ulcer to the right proximal, lateral foot and the Stage IV pressure ulcer (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible) to the left distal, lateral foot. The Skin and Wound Evaluation dated 8/30/22, indicated R13 had a Stage IV pressure ulcer to the left thigh measuring 4.7 cm x 0.5 cm with 80% granulation tissue. The documentation did not include any other tissue type. R13's medical record lacked evidence of a Skin and Wound Evaluation for 9/6/22 and 9/13/22. Vohra Wound Physicians Wound Evaluation and Management Summary, dated 8/30/22, indicated R13 was examined to have a Stage III pressure ulcer of the proximal, lateral left foot (1.1 cm (centimeters -length) x 0.9 cm (width) x non measurable (depth); 0.99 cm surface area (length	{F 686}		

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{F 686}	Continued From page 10 x width); 100% granulation (signs of healing tissue) and a Stage IV pressure ulcer of the distal, lateral right foot 1.0 cm x 0.9 cm x 0.3 cm; 0.90 cm surface area; 10% granulation tissue and 90% slough. Vohra Wound Physicians Wound Evaluation and Management Summary, dated 9/19/22, indicated R13 was examined to have a Stage III pressure ulcer of the proximal, lateral left foot 0.8 cm x 0.3 cm x 0.2 cm; 0.24 cm surface area; 100% granulation tissue and a Stage IV pressure ulcer of the distal, lateral right foot 1.2 cm x 0.4 cm x 0.2 cm; 0.48 cm surface area; 60% granulation tissue, 20% eschar (thick, nonadherent black tissue), 10% slough, and 10% other viable tissues. R13's medical record lacked evidence of a wound evaluation dated 9/6/22 and 9/13/22. R14's admission identified R14 was admitted on June 2022 with diagnosis of stage IV pressure ulcer of the right lower back, sacrum, left heel, and other site unnamed; and stage III pressure ulcer of the right heel and other site unnamed. R14's quarterly MDS dated 9/14/22, indicated R14 was cognitively intact and was free of exhibited rejection of care(s). R13 required extensive physical assist of two persons for bed mobility, transfers, dressing, and toilet use. In addition, the MDS identified R14 was at risk for pressure ulcers based on clinical assessments in which R14 presented with six Stage IV pressure ulcers and two Stage III pressure ulcers. R14's care plan dated 8/31/22, indicated R14 had actual skin impairment with interventions for	{F 686}		

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{F 686}	Continued From page 11 weekly documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate with the Vohra wound doctor and to report abnormalities, failure to heal, signs and symptoms of infection, and maceration to the medical doctor. The Skin and Wound Evaluation dated 8/30/22, indicated R14 had a Stage IV pressure ulcer to the right trochanter measuring 9.7 cm x 6.7 cm with 50% granulation tissue. The documentation did not include any other tissue type. R14's medical record lacked evidence of a wound evaluation completed for the five other Stage IV pressure ulcers and the two Stage III pressure ulcers. Further, lacked evidence of wound evaluations for 9/6/22 and 9/13/22. The Skin and Wound Evaluation dated 9/19/22, indicated R14 had a Stage IV pressure ulcer to the right shin measuring 1.6 cm x 1.2 cm with 10% granulation tissue and 80% slough with no other tissue type mentioned. A Stage IV pressure ulcer to the right heel measuring 5.0 cm x 2.4 cm with 70% granulation tissue and 20% slough with no other tissue type mentioned. A Stage IV pressure ulcer to the sacrum measuring 4.9 cm x 3.4 cm with 80% granulation and 10% slough with no other tissue type mentioned. A Stage IV pressure ulcer to the left thigh measuring 19.6 cm x 7.5 cm with 80% granulation and 10% slough with no other tissue type mentioned. A Stage III to the left knee measuring 3.5 cm x 3.2 cm with 60% granulation tissue and 30% slough with no other tissue type mentioned. A Stage IV to the left lateral malleolus measuring 2.5 cm x 1.3 cm with 100% eschar. A Stage II to the left lateral foot measuring 4.2 cm x 2.0 cm with 70% granulation	{F 686}		

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{F 686}	Continued From page 12 tissue and 20% eschar with no other tissue type mentioned. Vohra Wound Physicians Wound Evaluation and Management Summary, dated 9/19/22, indicated R14 was examined to have a Stage IV pressure ulcer of the posterior left thigh 20 cm x 14.3 cm x 2.9 cm; 286.0 cm surface area; 80% granulation, 10% slough, and 10% other viable tissue (bone, muscle, dermis); a Stage IV pressure ulcer of the right ischium 13.5 cm x 10.2 cm x 2.8 cm; 137.70 cm surface area; 80% granulation, 10% slough, and 10% other viable tissue (bone, muscle); a Stage III pressure ulcer of the left knee 3.6 cm x 5.1 cm x 0.1 cm; 18.36 cm surface area; 60% granulation, 30% slough, 10% other viable tissue; a Stage IV pressure ulcer of the right heel 4.7 cm x 3.5 cm x 0.5 cm; 16.45 cm surface area; 70% granulation, 20% slough, and 10% other viable tissue (dermis, muscle); a Stage IV of the left heel 0.8 cm x 1.6 cm x 0.1 cm; 1.28 cm surface area; 80% granulation, 10% slough, and 10% other viable tissue; a Stage IV pressure ulcer of the sacrum 7.2 cm x 4.6 cm x 2.6 cm; 33.12 cm surface area; 90% granulation and 10% slough; a Stage IV pressure ulcer of the left lateral foot 4.6 cm x 2.8 cm x 0.3 cm; 12.88 cm surface area; 70% granulation, 20% necrotic tissue, and 10% other viable tissue (muscle, dermis); a Stage III pressure ulcer of the left lateral ankle 2.7 cm x 0.9 cm x 0.3 cm; 80% granulation, 10% necrotic tissue, and 10% other viable tissue (dermis, muscle); and a Stage III pressure ulcer of the right shin 0.9 cm x 1.4 cm x 0.1 cm; 1.26 cm surface area; 10% granulation, 80% slough, and 10% other viable tissue. R14's medical record lacked evidence of Vohra wound evaluations for 9/6/22 and 9/13/22.	{F 686}		

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{F 686}	Continued From page 13 Upon interview on 9/29/22, at 11:02 a.m. the Vohra wound doctor stated the first day of wound assessments he completed were on 9/19/22 and arrived at the facility on 9/26/22 to complete the wound assessments, however, was made aware there wasn't a nurse to do rounds with him so the wound assessments did not get completed. Further, stated he wasn't aware of any wound assessments being completed between 8/30/22 to 9/19/22. Upon interview on 9/29/22, at 11:10 a.m. the licensed practical nurse manager (LPN)-A stated all wounds should be assessed every week to prevent worsening of the wound and/or infections. LPN-A verified the wounds had not been assessed weekly per protocol. An undated policy Wound Care identified the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The policy directed staff to verify the physician order prior to the treatment and document specific information in the resident's medical record after completion i.e. type of wound care provided, any changes in the resident's condition, all assessment data obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints reported, and if the resident refused the treatment and the reason why. In addition, the policy directed to notify the supervisor if the resident refused the wound care and to report other information in accordance with facility policy and professional standards of practice. Surveyor: 43080	{F 686}		

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{F 686}	Continued From page 14 Surveyor: 43083	{F 686}		
{F 756} SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	{F 756}		10/28/22

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{F 756}	Continued From page 15 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Surveyor: 46885 Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were acted upon, addressed, and documented in the medical record for 2 of 2 residents (R4 and R11) who received recommendations from the pharmacist. Findings include: R4's quarterly Minimum Data Set (MDS) dated 7/20/22, indicated intact cognition. R4's diagnoses in the MDS included anxiety and depression. R4's medication administration record (MAR) for September 2022, indicated R4 had an order that started 5/27/22, for lorazepam 1 milligram by mouth as needed for anxiety three times before the use of hoyer. R4's Consultant Pharmacist's Medication Review dated 8/3/22, indicated R4 had been prescribed Ativan since 5/27/22, however there was no stop date listed for the MAR. Additionally, clinical rational for continuing medication was needed. The review also indicated R4 had not used the medication in over a month and the suggestion was to either discontinue the as needed medication, or provide a rationale as to why it is necessary along with a duration for extending the order. The review was digitally signed by the pharmacist.	{F 756}	1. R4, R11 pharmacy recommendations were reviewed and acted upon 2. All pharmacy recommendations for resident with recommendation were reviewed acted upon 3. DON or designee will review pharmacy recommendations monthly 4. DON or designee will complete pharmacy recommendation monthly 5. QAPI will monitor pharmacy recommendations	

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{F 756}	Continued From page 16 R4's Associated Clinic of Psychology evaluation note dated 9/26/22, indicated R4 was not aware she could have lorazepam if needed before cares, and did not want to feel the effect of the medication because the anxiety only lasted moments. The note indicated R4 was fine to keep the lorazepam in instances when she felt she could not come back from her anxiety. The note did not indicate a duration for extending the lorazepam. R11's significant change MDS dated 8/3/22 indicated R11 had a diagnoses of a fracture and other multiple trauma. R11's MAR for September 2022, indicated R11 had an order that started 4/26/22, for a Lidocaine patch five percent with instructions to apply one patch transdermally every 12 hours as needed for pain. R11's Consultant Pharmacist's Medication Review dated 8/3/22, indicated R11's Lidocaine five percent transdermal patch should have a maximum application period time of 12 hours per patch, with a 12 hour drug-free interval per the manufacturer. The review indicated a recommendation to change the administration instructions to include, "Please make sure patch is removed after 12 hours." The review was digitally signed by the pharmacist. During interview on 9/29/22, at 1:38 p.m. licensed practical nurse (LPN)-A stated the pharmacy review is faxed to the physician immediately and the physician will reply on the pharmacy review form. LPN-A stated R4 was seen by the psychiatrist on 9/26/22, but stated nobody	{F 756}		

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{F 756}	Continued From page 17 addressed the pharmacist review. LPN-A stated there was no other place for the order to be found for R11's pharmacist medication review and LPN-A stated after he reviewed the chart, the orders were not clarified. Surveyor: 43080 Surveyor: 43083	{F 756}		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to ensure concerns identified on the previous survey had appropriate oversight by the administrator to ensure the facility corrected deficient practice and use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice had the potential to affect all 65 residents at the facility. Refer to F607, F684, F686, and F756. Findings include:	F 835	1. Facility obtained a full time DON 2. Administrator reviewed policies and advised as necessary 3. Administrator education DON on the importance of correcting deficiencies 4. IDT sat and reviewed deficiencies and put together a plan of correction 5. Administrator will meet with DON daily to ensure that audits are being done and plan of correction is being followed. 6. IDT team will meet daily to ensure that all audits are being completed according to the schedules set for respective audits. 7. Administrator will meet with Regional Director of Operations weekly to update on status and progress of POC and other	11/4/22

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F 835	Continued From page 18 Review of current facility policies and procedures, documentation, resident's medical records identified current deficient practice remained. Interview on 9/27/22 at 1126 a.m., with the administrator identified he had not overseen work performed by the former director of nursing (DON) to ensure deficient practice was corrected. The administrator stated, "No plans of correction have been done ...the past DON didn't complete anything ...no education ...nothing ...so we know you will have to recite them all and we are now going to get to work on it all." No policy or procedure on administrative oversight was provided by the end of the survey.	F 835	pertinent information regarding the facility.	

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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: Surveyor: 43007 On 9/27/22, 9/28/22, and 9/29/22, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 8/9/22 by the Minnesota Department of Health (MDH). Your facility was found to be NOT in	{2 000}		

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{2 000}	Continued From page 1 compliance with the MN State Licensure and were found to be NOT to be corrected. The original licensing order issued will remain in effect. Penalty assessment issued. The complaint H52893729C (MN85651, MN85680, MN85664), which was SUBSTANTIATED, with licensing orders previously issued at 0900 and 1530 at the time of the survey was also reviewed for compliance and found NOT to be corrected and remain OUT OF COMPLIANCE. 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 surveyors 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 <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	{2 000}		

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{2 000}	Continued From page 2 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. 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. Surveyor: 43083	{2 000}		
2 130	MN Rule 4658.0050 Subp. 1 Licensee;General duties Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	2 130		10/22/22

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2 130	Continued From page 3 This MN Requirement is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to ensure concerns identified on the previous survey had appropriate oversight by the administrator to ensure the facility corrected deficient practice and use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice had the potential to affect all 65 residents at the facility. See also 0900 and 1530 Findings include: Review of current facility policies and procedures, documentation, resident's medical records identified current deficient practice remained. Interview on 9/27/22 at 1126 a.m., with the administrator identified he had not overseen work performed by the former director of nursing (DON) to ensure deficient practice was corrected. The administrator stated "No plans of correction have been done ...the past DON didn ' t complete anything ...no education..nothing ...so we know you will have to recite them all and we are now going to get to work on it all." No policy or procedure on administrative oversight was provided by the end of the survey. SUGGESTED METHOD OF CORRECTION:	2 130	1. Facility obtained full time DON 2. Administrator educated DON on the importance of correcting deficiencies 3. IDT sat and reviewed deficient practices and put together plan of correction	

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2 130	Continued From page 4 The governing body and or medical director should review current policies and procedures, and industry standards for implementing appropriate changes for the quality, health, and safety of their resident population. The governing body and or medical director should complete audits of resident cares, resident satisfaction surveys, staffing patterns and staff competency. etc. to ensure resident needs are consistently met and deficient practice is corrected. The results of those measurable audits should be taken to the QAPI committee to determine ongoing compliance with oversight of facility operations. TIME PERIOD FOR CORRECTION: 21 days.	2 130		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by:	{2 900}		10/28/22

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{2 900}	Continued From page 5 Surveyor: 43007 Based on interview and document review, the facility failed to ensure residents identified at risk for worsening pressure ulcers received the necessary monitoring and assessments to decrease the risk of worsening wounds and decreased healing for 2 of 2 residents (R13 and R14) with pressure ulcers. Findings include: R13's admission record identified R13 was admitted to the faciity in May 2019 with a previous history of a Stage II pressure ulcer (Partial-thickness loss of skin with exposed dermis) to the sacral (lower back) region, a Stage I pressure ulcer (Intact skin reddened skin) of the right heel, and an unstageable pressure ulcer (Full-thickness skin and tissue loss) of the left heel. R13's quarterly Minimum Data Set (MDS), dated 9/1/22, indicated R13 was cognitively intact and was free of exhibited rejection of care(s). R13 required extensive physical assist of two persons for bed mobility, transfers, dressing, personal hygiene, and toilet use. R13 was at risk for pressure ulcers and required pressure ulcer care. R13's care plan dated 5/3/22, indicated R13 had a Stage II pressure ulcer of the left posterior thigh related to moisture with an intervention for weekly documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate with the Vohra wound doctor. The care plan lacked evidence of documentation of the Stage III pressure ulcer to the right proximal, lateral foot and the Stage IV pressure ulcer (Full-thickness skin and tissue loss	{2 900}	1. R13, R14 skin assessments were completed and any skin alterations addressed 2. All residents will have a Braden Assessment complete and any skin alterations addressed 3. Nursing staff will be educated on how to complete a Braden Assessment. Facility will conduct monthly Braden Assessments on residents 4. DON or designee will audit skin assessments weekly for 6 weeks 5. IDT will monitor audit during QAPI	

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{2 900}	Continued From page 6 with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible) to the left distal, lateral foot. The Skin and Wound Evaluation dated 8/30/22, indicated R13 had a Stage IV pressure ulcer to the left thigh measuring 4.7 cm x 0.5 cm with 80% granulation tissue. The documentation did not include any other tissue type. R13's medical record lacked evidence of a Skin and Wound Evaluation for 9/6/22 and 9/13/22. Vohra Wound Physicians Wound Evaluation and Management Summary, dated 8/30/22, indicated R13 was examined to have a Stage III pressure ulcer of the proximal, lateral left foot (1.1 cm (centimeters -length) x 0.9 cm (width) x non measurable (depth); 0.99 cm surface area (length x width); 100% granulation (signs of healing tissue) and a Stage IV pressure ulcer of the distal, lateral right foot 1.0 cm x 0.9 cm x 0.3 cm; 0.90 cm surface area; 10% granulation tissue and 90% slough. Vohra Wound Physicians Wound Evaluation and Management Summary, dated 9/19/22, indicated R13 was examined to have a Stage III pressure ulcer of the proximal, lateral left foot 0.8 cm x 0.3 cm x 0.2 cm; 0.24 cm surface area; 100% granulation tissue and a Stage IV pressure ulcer of the distal, lateral right foot 1.2 cm x 0.4 cm x 0.2 cm; 0.48 cm surface area; 60% granulation tissue, 20% eschar (thick, nonadherent black tissue), 10% slough, and 10% other viable tissues. R13's medical record lacked evidence of a wound evaluation dated 9/6/22 and 9/13/22.	{2 900}		

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{2 900}	Continued From page 7 R14's admission identified R14 was admitted on June 2022 with diagnosis of stage IV pressure ulcer of the right lower back, sacrum, left heel, and other site unnamed; and stage III pressure ulcer of the right heel and other site unnamed. R14's quarterly MDS dated 9/14/22, indicated R14 was cognitively intact and was free of exhibited rejection of care(s). R13 required extensive physical assist of two persons for bed mobility, transfers, dressing, and toilet use. In addition, the MDS identified R14 was at risk for pressure ulcers based on clinical assessments in which R14 presented with six Stage IV pressure ulcers and two Stage III pressure ulcers. R14's care plan dated 8/31/22, indicated R14 had actual skin impairment with interventions for weekly documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate with the Vohra wound doctor and to report abnormalities, failure to heal, signs and symptoms of infection, and maceration to the medical doctor. The Skin and Wound Evaluation dated 8/30/22, indicated R14 had a Stage IV pressure ulcer to the right trochanter measuring 9.7 cm x 6.7 cm with 50% granulation tissue. The documentation did not include any other tissue type. R14's medical record lacked evidence of a wound evaluation completed for the five other Stage IV pressure ulcers and the two Stage III pressure ulcers. Further, lacked evidence of wound evaluations for 9/6/22 and 9/13/22. The Skin and Wound Evaluation dated 9/19/22, indicated R14 had a Stage IV pressure ulcer to	{2 900}		

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{2 900}	Continued From page 8 the right shin measuring 1.6 cm x 1.2 cm with 10% granulation tissue and 80% slough with no other tissue type mentioned. A Stage IV pressure ulcer to the right heel measuring 5.0 cm x 2.4 cm with 70% granulation tissue and 20% slough with no other tissue type mentioned. A Stage IV pressure ulcer to the sacrum measuring 4.9 cm x 3.4 cm with 80% granulation and 10% slough with no other tissue type mentioned. A Stage IV pressure ulcer to the left thigh measuring 19.6 cm x 7.5 cm with 80% granulation and 10% slough with no other tissue type mentioned. A Stage III to the left knee measuring 3.5 cm x 3.2 cm with 60% granulation tissue and 30% slough with no other tissue type mentioned. A Stage IV to the left lateral malleolus measuring 2.5 cm x 1.3 cm with 100% eschar. A Stage II to the left lateral foot measuring 4.2 cm x 2.0 cm with 70% granulation tissue and 20% eschar with no other tissue type mentioned. Vohra Wound Physicians Wound Evaluation and Management Summary, dated 9/19/22, indicated R14 was examined to have a Stage IV pressure ulcer of the posterior left thigh 20 cm x 14.3 cm x 2.9 cm; 286.0 cm surface area; 80% granulation, 10% slough, and 10% other viable tissue (bone, muscle, dermis); a Stage IV pressure ulcer of the right ischium 13.5 cm x 10.2 cm x 2.8 cm; 137.70 cm surface area; 80% granulation, 10% slough, and 10% other viable tissue (bone, muscle); a Stage III pressure ulcer of the left knee 3.6 cm x 5.1 cm x 0.1 cm; 18.36 cm surface area; 60% granulation, 30% slough, 10% other viable tissue; a Stage IV pressure ulcer of the right heel 4.7 cm x 3.5 cm x 0.5 cm; 16.45 cm surface area; 70% granulation, 20% slough, and 10% other viable tissue (dermis, muscle); a Stage IV of the left heel 0.8 cm x 1.6 cm x 0.1 cm; 1.28 cm surface area; 80% granulation, 10% slough, and 10%	{2 900}		

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{2 900}	Continued From page 9 other viable tissue; a Stage IV pressure ulcer of the sacrum 7.2 cm x 4.6 cm x 2.6 cm; 33.12 cm surface area; 90% granulation and 10% slough; a Stage IV pressure ulcer of the left lateral foot 4.6 cm x 2.8 cm x 0.3 cm; 12.88 cm surface area; 70% granulation, 20% necrotic tissue, and 10% other viable tissue (muscle, dermis); a Stage III pressure ulcer of the left lateral ankle 2.7 cm x 0.9 cm x 0.3 cm; 80% granulation, 10% necrotic tissue, and 10% other viable tissue (dermis, muscle); and a Stage III pressure ulcer of the right shin 0.9 cm x 1.4 cm x 0.1 cm; 1.26 cm surface area; 10% granulation, 80% slough, and 10% other viable tissue. R14's medical record lacked evidence of Vohra wound evaluations for 9/6/22 and 9/13/22. Upon interview on 9/29/22, at 11:02 a.m. the Vohra wound doctor stated the first day of wound assessments he completed were on 9/19/22 and arrived at the facility on 9/26/22 to complete the wound assessments, however, was made aware there wasn't a nurse to do rounds with him so the wound assessments did not get completed. Further, stated he wasn't aware of any wound assessments being completed between 8/30/22 to 9/19/22. Upon interview on 9/29/22, at 11:10 a.m. the licensed practical nurse manager (LPN)-A stated all wounds should be assessed every week to prevent worsening of the wound and/or infections. LPN-A verified the wounds had not been assessed weekly per protocol. An undated policy Wound Care identified the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The policy directed staff to verify the	{2 900}		

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{2 900}	Continued From page 10 physician order prior to the treatment and document specific information in the resident's medical record after completion i.e. type of wound care provided, any changes in the resident's condition, all assessment data obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints reported, and if the resident refused the treatment and the reason why. In addition, the policy directed to notify the supervisor if the resident refused the wound care and to report other information in accordance with facility policy and professional standards of practice. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. Surveyor: 43083	{2 900}		

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{21530}	Continued From page 11	{21530}		
{21530}	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality	{21530}		10/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: _____ B. WING _____	R-C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT CRYSTAL LLC	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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{21530}	Continued From page 12 assessment and assurance committee. This MN Requirement is not met as evidenced by: Surveyor: 43007 Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were acted upon, addressed, and documented in the medical record for 2 of 2 residents (R4 and R11) who received recommendations from the pharmacist. Findings include: R4's quarterly Minimum Data Set (MDS) dated 7/20/22, indicated intact cognition. R4's diagnoses in the MDS included anxiety and depression. R4's medication administration record (MAR) for September 2022, indicated R4 had an order that started 5/27/22, for lorazepam 1 milligram by mouth as needed for anxiety three times before the use of hoyer. R4's Consultant Pharmacist's Medication Review dated 8/3/22, indicated R4 had been prescribed Ativan since 5/27/22, however there was no stop date listed for the MAR. Additionally, clinical rational for continuing medication was needed. The review also indicated R4 had not used the medication in over a month and the suggestion was to either discontinue the as needed medication, or provide a rationale as to why it is necessary along with a duration for extending the order. The review was digitally signed by the pharmacist.	{21530}	1. R4, R11 pharmacy recommendations were reviewed and acted upon 2. All pharmacy recommendations for resident with recommendation were reviewed acted upon 3. DON or designee will review pharmacy recommendations monthly 4. DON or designee will complete pharmacy recommendation monthly 5. QAPI will monitor pharmacy recommendations	

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{21530}	Continued From page 13 R4's Associated Clinic of Psychology evaluation note dated 9/26/22, indicated R4 was not aware she could have lorazepam if needed before cares, and did not want to feel the effect of the medication because the anxiety only lasted moments. The note indicated R4 was fine to keep the lorazepam in instances when she felt she could not come back from her anxiety. The note did not indicate a duration for extending the lorazepam. R11's significant change MDS dated 8/3/22 indicated R11 had a diagnoses of a fracture and other multiple trauma. R11's MAR for September 2022, indicated R11 had an order that started 4/26/22, for a Lidocaine patch five percent with instructions to apply one patch transdermally every 12 hours as needed for pain. R11's Consultant Pharmacist's Medication Review dated 8/3/22, indicated R11's Lidocaine five percent transdermal patch should have a maximum application period time of 12 hours per patch, with a 12 hour drug-free interval per the manufacturer. The review indicated a recommendation to change the administration instructions to include, "Please make sure patch is removed after 12 hours." The review was digitally signed by the pharmacist. During interview on 9/29/22, at 1:38 p.m. licensed practical nurse (LPN)-A stated the pharmacy review is faxed to the physician immediately and the physician will reply on the pharmacy review form. LPN-A stated R4 was seen by the psychiatrist on 9/26/22, but stated nobody addressed the pharmacist review. LPN-A stated there was no other place for the order to be found	{21530}		

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{21530}	Continued From page 14 for R11's pharmacist medication review and LPN-A stated after he reviewed the chart, the orders were not clarified. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications to ensure recommendations are acted upon. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring recommendations are acted upon ASAP. Audits should be developed to monitor timliness of action from physician, using appropriate timeframes for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS Surveyor: 43083	{21530}		