



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 27, 2024

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

RE: CCN: 245272
Cycle Start Date: April 18, 2024

Dear Administrator:

On May 31, 2024 and June 3, 2024, the Minnesota Departments of Health and Public Safety, completed revisits to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in blue ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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Electronically delivered
April 29, 2024

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

RE: CCN: 245272
Cycle Start Date: April 18, 2024

Dear Administrator:

On April 18, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 18, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 18, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

Martin Luther Care Center

April 29, 2024

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specified for compliance or the imposition of remedies.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 05/09/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/18/2024
NAME OF PROVIDER OR SUPPLIER MARTIN LUTHER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 EAST 100TH STREET BLOOMINGTON, MN 55425		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 4/15/24 through 4/18/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 4/15/24 to 4/18/24, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were also completed. Martin Luther Care Center was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H52723045C (MN095184) H52722992C (MN095618) H52723046C (MN097603) H52723047C (MN097914 and MN097922) H52722993C (MN100548) H52722993C (MN100510) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/06/2024

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 550 SS=D	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 substantial compliance with the regulations has been attained. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550			5/28/24

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F 550	Continued From page 2 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely assistance with elimination care was provided, when requested, to promote dignity and reduce the risk of complication (i.e., incontinence) for 1 of 2 residents (R182) reviewed for dignity with personal care. Findings include: R182's "N Adv" Brief Interview For Mental Status (BIMS) Evaluation (a screening tool used to determine cognition), dated 4/10/24, identified R182 had intact cognition. On 4/15/24 at 5:45 p.m., R182 was observed lying in bed while in her room. R182 was interviewed, and explained she had admitted to the care center about a week prior and was mostly bed-ridden due to a sustained injury adding she could only use a bed pan for various elimination needs due to the immobility. R182 stated "the biggest complaint" about the care center was staff who respond to her calls for assistance, and then express they will "be right back" but not then return timely, if at all. R182 stated this had happened many times since she	F 550	Corrective Action: R182 was assisted with toileting. Corrective Action as it applies to other residents: The call light policy was reviewed and remains current. The dignity policy was reviewed and remains current. All staff will be re-educated on the call light policy. All staff were re-educated on the dignity policy. Reoccurrence will be prevented by: Random observational audits will be conducted to ensure the call light policy is followed. 3 random audits will be completed weekly for 4 weeks, then 2 random observational audits will be completed weekly for 4 weeks. Random observational audits to ensure the dignity policy is followed. 3 random audits will be completed weekly for 4 weeks, then 2 random audits for observational audits will be completed weekly for 4 weeks. The results of the audits will be brought to the QAPI committee meeting for review and further discussion.		

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F 550	Continued From page 3 admitted. On 4/17/24 at 8:46 a.m., medication administration was observed with registered nurse (RN)-D preparing medications for R182's roommate at a mobile cart in the hallway of the transitional care unit (TCU). RN-D then brought the prepared medications to R182's roommate who was in the shared room. As RN-D entered the room, with the surveyor present, the nursing assistant (NA)-D was inside and asked aloud, "I need help turning her [R182]." NA-D then left the room while RN-D provided R182's roommate with medication. RN-D then left the room saying aloud, "I am going to chart [the medications]." At 8:49 a.m., R182 was observed lying in bed with a pink-colored bed pan present sitting by her feet and her covered meal tray on her bedside table. R182 stated aloud, "I won't be able to go [void/eliminate] by the time everybody gets here, that's the way that works." At 8:52 a.m., R182 remained lying in bed and no staff, including NA-D or RN-D had returned to provide assistance. R182 stated she wished the care center would adjust night shift staff's hours to better help with early morning cares. R182 looked at the wall-mounted clock in her room and explained she had first asked for help around "five to ten after eight [a.m.]," but added, "I can't be sure." R182 stated staff then responded "pretty quick" but, again, then said they would "be right back" adding, "Then I never saw her again." R182 stated she then used the call light to get help with the bed pan and "this gal [NA-D]" responded just before the surveyor entered the room with RN-D present. At 8:57 a.m., a physical therapist assistant (PTA)-A entered the room and stated they wanted	F 550	The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.		

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F 550	Continued From page 4 to check on R182 for a morning therapy session. PTA-A stated aloud, "How's it going?" R182 responded with, "My legs' really been hurting," adding, "I am still waiting for the bed pan." PTA-A acknowledged R182 waiting and responded, "I will check back later." PTA-A then left the room. At 8:59 a.m. (over 10 minutes later), R182 remained in bed with no assistance being provided yet. R182 stated having to wait for help caused her to feel, "Frustrated." R182 stated situations like this, with having to wait for help to return, happened often and expressed aloud, "This is awful," adding further, "You're here for help and it just seems like they don't have it to give." R182 stated her meal tray had arrived "just a few minutes before you came [surveyor entered the room]," and expressed she ordered pancakes but, after waiting so long for help, added aloud, "They won't be hot cakes any longer." At 9:09 a.m., R182 remained in bed with neither RN-D or NA-D having returned to assist her with the bed pan. R182 stated she no longer needed to use it though as the urge had passed due to waiting so long for help adding, "That's not good, either." At 9:12 a.m. (over 20 minutes later), R182 remained without any return of staff to help assist her with elimination as she had requested. As a result, the surveyor alerted NA-B and registered nurse unit manager (RN)-E, whom were in the hallway outside R182's room, about R182's need for help. NA-B immediately donned a gown and entered to assist R182. At 9:15 a.m., NA-D, whom had originally said they needed help to turn R182 to provide the bed pan, was observed pushing another resident to their room from the dining room. Immediately following, RN-D was interviewed and explained they were still "trying to find someone" to help turn R182 when NA-D	F 550			

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F 550	Continued From page 5 joined the conversation. NA-D stated they had "got pulled to the other side" to help and verified they had not yet returned to R182's room to either assist or provide an explanation for the delay in care. NA-D stated the delay, in part, was due to the morning meal tray pass adding, "It's hard cause of the trays." NA-D stated staff typically always tried to respond to call lights and resident' requests timely. When interviewed on 4/17/24 at 9:18 a.m., RN-D verified they had not returned to assist R182 since themselves and the surveyor entered the room. RN-D stated they thought NA-D was going to help but then NA-D left the area and "did not tell me" adding there had been some confusion about the situation and who exactly was going to assist her. RN-D stated staff usually tried to respond "right away," but again reiterated, "We got confused." RN-D stated they felt call lights and requests were often addressed timely, however, the shift that day had someone show up late which also had caused some delays. Further, RN-D stated it was important to ensure resident' requests for assistance were met timely to promote quality of life adding, "We don't want them to suffer." R182's provided Responder 500 Report, dated 4/17/24, identified R182's call light activation and response times for the period. This identified R182 activated her call light at 8:37 a.m. and staff responded seven minutes and 53 seconds later (approximately 8:45 a.m.). On 4/17/24 at 11:10 a.m., RN-E was interviewed. RN-E explained staff "often times" will be helping a resident with care when another needs assistance so, as a result, staff were told to check	F 550			

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F 550	Continued From page 6 in with the resident and "let them know" when they could return to help them. However, that morning (on 4/17/24), a staff member had accidentally "slept in" which caused the NA(s) to be moved to other units and "switched around" which may have caused "a miscommunication." RN-E stated a NA being pulled or moved happened on "a weekly" basis and expressed staff should ensure they're communicating with each other adding they needed to do some education with them. RN-E stated it was important to ensure resident' requests for help were addressed timely as, "Customer service is number one."	F 550			
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must--	F 577			5/13/24

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F 577	Continued From page 7 (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure complaint investigations regarding the facility during the three preceding years, and any plan of correction in effect with respect to the facility and posting of notice of availability of such reports were posted in areas of the facility that were prominent and accessible to the public. This had the potential to affect all 132 residents, families and visitors who may have wished to review the information. Findings include: According to the Federal database Automated Survey Processing Environment (ASPEN) in 2023, facility had in-person complaint investigations on 4/3/23, 6/22/23,5/18/23, 6/8/23, 6/21/237/20/23, 8/2/23, 9/28/23. Per ASPEN deficiencies were issued for 5/18/23 and 8/2/23. During observation on 4/17/24 at 11:08 a.m., review of Martin Luther Care Center Annual State	F 577	Complaint investigations were added to the survey binder in the lobby immediately. The Public Posting policy was reviewed and revised. Re-education was completed with the administrator. Audits will be completed 1 time per month for 3 months to ensure compliance. The administrator or designee is responsible for ensuring compliance.		

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F 577	Continued From page 8 Survey Results located in main lobby of facility on small table inside front door failed to include any complaint investigation results including the facility's plan of correction were present for the year 2023. Facility lobby also failed to have any posting of notice of availability of such reports. During interview with administrator on 4/17/24 at 12:47 p.m., administrator stated she was responsible for updating the Martin Luther Care Center Annual State Survey Results binder in the lobby with survey and complaint results. Administrator stated, "...I know I have put the complaint results in that binder. The binder should have complaint and survey results for the past 3 years". Also, the administrator stated there was no signage in the binder, lobby or elsewhere in the facility to indicated where the residents, family, and visitors could review complaint survey results. Facility policy titled Required Postings-State Survey Results with revision date of 6/1/23 directs, "Survey results must be: ii. Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and iii. Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public." Also, "DEFINITIONS: ""Results of the most recent survey" means the Statement of Deficiencies and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting	F 577			

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F 577	Continued From page 9	F 577			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced	F 583			5/28/24

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F 583	Continued From page 10 by: Based on observation, interview and document review, the facility failed to ensure resident medical records which contained private, medical, and personal information were kept private and not accessible to unauthorized personnel for 2 of 2 residents (R230 and R6) reviewed for privacy. Findings include: During observation on 4/16/24 at 8:19 a.m., an unattended medication cart in the hallway in the west side of the Transitional Care Unit (TCU) with laptop open to R230's medication list was observed. During interview with registered nurse (RN)-A on 4/16/21 at 8:21 a.m., RN-A stated he was responsible for the unattended TCU medication cart with R230's medication list visible on the laptop screen. RN-A stated, "when I leave med cart I should hide the resident info on the laptop and lock med cart." During observation and interview on 4/18/24 at 1:27 p.m., an unattended medication cart with a laptop open to R6's electronic medical record was observed in the 2nd floor east hallway of the long term care unit of facility. RN-G approached medication cart with a rolling vital sign equipment and stated she was responsible for the unattended medication cart and, "yes this screen is visible to anyone who is near and I should not have left it open. I am so busy and forgot. It should be closed when I leave the cart for patient privacy and HIPAA (health insurance portability and accountability act)". During interview with charge nurse, RN-C on	F 583	Corrective Action: The lock screen was placed on the computer to protect the privacy of R230 and R6. Corrective Action as it applies to other residents: New privacy screens were ordered. The privacy policy was reviewed and remains current. Staff responsible for computer use in public spaces were educated on the privacy policy. Date of Completion: 5/28/24 Reoccurrence will be prevented by: Random observational audits will be conducted to ensure the privacy policy is followed and the computers are free of protected information when there is no one at the cart. 3 random audits will be completed weekly for 4 weeks, then 2 random audits for observational audits will be completed weekly for 4 weeks. The results of the audits will be brought to the QAPI committee meeting for review and further discussion. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.		

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F 583	Continued From page 11 4/17/24 at 8:08 a.m., RN-C stated, "When you leave [it], med cart is to be locked and screen locked for patient privacy." During interview with RN-F on 4/18/24 at 8:26 a.m., RN-F stated, "any time I leave the med cart, I turn screen off of computer with any kind of patient information shown and lock the cart. [It is] important for patient privacy." During interview with director of nursing (DON) on 4/18/24 at 12:11 p.m., DON stated, "[left open laptops] with patient identifying information should never be visible [to anyone but authorized staff]" and the rationale as, "patient privacy of records." Facility policy titled Medication Administration-General Guidelines with review date of 3/10/23, state, "privacy is maintained at all times for all resident information (e.g., MAR) by blanking the computer screen when not in use."	F 583			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., nail care) was provided for 1 of 1 resident (R64) reviewed for activities of daily living (ADLs) who was dependent on staff for their care. Findings include:	F 677	Corrective Action: Resident R64 was offered nail care, care plan was updated to reflect the refusals of care. Corrective Action as it applies to other residents: The policy for nail care was reviewed and remains current. All nursing staff were re-educated on the nail care		5/28/24

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F 677	Continued From page 12 R64's quarterly Minimum Data Set (MDS) dated 2/28/24, indicated R64 had moderate cognitive impairment, needed substantial/maximal assistance with personal hygiene, dressing, eating, oral hygiene and was dependent on toileting and showering. R64's MDS did not indicate behaviors or refusal of cares. R64's Clinical Diagnosis Report printed 4/18/24, indicated diagnoses of vascular dementia (problems with reasoning, planning, judgement, memory, and other thought processes caused by brain damage from impaired blood flow to the brain), type II diabetes mellitus with diabetic neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), major depressive disorder, peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), below left and right knee amputation, and hypertension. R64's Activities of daily living (ADL) care plan indicated R64 had a self-care performance deficit and required assistance with personal hygiene. R64's care plan, MDS and electronical medical record lacked documentation R36 refused personal cares. During observation on 4/15/24 at 6:13 p.m. R64's nails were about 0.4 centimeters (cm) long and had black debris underneath his fingernails. During observation on 4/16/24 at 1:14 p.m., R64 was in bed watching television, scratched his head and touched his face several times. R64 fingernails were about 0.4 cm long and had black			F 677	policy. Reoccurrence will be prevented by: Random observational audits will be conducted to ensure the nail care policy is followed nail care is completed, refusals are documented and consistent refusals are care planned. 3 random audits will be completed weekly for 4 weeks, then 2 random audits for observational audits will be completed weekly for 4 weeks. The results of the audits will be brought to the QAPI committee meeting for review and further discussion. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.		

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F 677	Continued From page 13 debris underneath. R64 was able to answer some questions but did not talk about his fingernails. During interview on 4/16/24 at 1:45 p.m., nursing assistant (NA)-F stated during morning cares staff assisted residents with personal grooming, including shaving, brushing their teeth, combing their hair, washing their arms, and hands. NA-F stated nail care was done on shower day but if a resident was diabetic the nurse did both finger and toenail care. During interview on 4/16/24 at 1:49 p.m., NA-E stated this morning she provided morning cares for R64 including washing his hands and helping him eat breakfast, and later helped R64 eat lunch. NA-E didn't notice R64 had black debris underneath all his fingernails until it was brought to her attention. NA-E verified R64's fingernails were about 0.4 cm long and had black matter underneath his fingernails. During interview on 4/16/24 at 1:59 p.m. registered nurse (RN)-F stated the concern with long dirty nails could be a source of infection. RN-F added, if R64 touches his food with his hands he could get sick. During interview on 4/16/24 at 2:01 p.m. nurse manager/registered nurse (RN)-I stated there were many concerns related to long dirty fingernails. Concerns included lack of cleanliness, potential for infections, and lack of dignity. RN-I stated, the interdisciplinary team needed to follow up and determine if there was a behavior pattern and revise R64's care plan. During interview on 4/17/24 at 11:39 a.m. director of nursing (DON) stated "you eat with your hands,	F 677			

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F 677	Continued From page 14 it is an infection control issue, consequently R64 can get sick." DON stated R64 care plan and interventions needed to be reviewed and updated to reflect his needs. Facility's policy titled Care of Nails dated 9/2022 indicated the purpose was to provide cleanliness, prevent spread of infection, comfort, and prevent skin problems.	F 677			
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: Based on observation, interview, and document review, the facility failed to ensure wound prevention treatment was implemented for 1 of 1 resident (R36) who had a history of bilateral heel pressure areas and risk for skin breakdown. Findings include: R36's annual Minimum Data Set (MDS) dated 4/8/24, indicated R36 had moderate cognitive	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Corrective Action: Resident R36 orders were reviewed, the provider was updated, the eMAR and the care plan were updated based on provider orders. Corrective Action as it applies to other residents: The Pressure Injury Prevention		5/28/24

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F 686	Continued From page 15 impairment, no delirium, or behaviors, and did not refuse cares. MDS indicated, R36 needed moderate assistance with upper body dressing, toileting, oral hygiene, and bathing. R36 needed maximal assistance with lower body dressing, putting on/taking off footwear, personal hygiene, and transfers. MDS also indicated, R36 was at risk to develop pressure areas. R36's Clinical Diagnosis Report printed 4/17/24, indicated diagnoses of type II diabetes mellitus (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), diabetes chronic kidney disease (a gradual loss of kidney function), vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), morbid obesity (a disorder involving excessive body fat that increases the risk of health problems), history of transient ischemic attack (temporary period of symptoms similar to those of a stroke that usually lasts a few minutes and doesn't cause permanent damage), dysphagia (difficulty swallowing), bunion left and right foot (a bony bump that forms on the joint at the base of the big toe), hypertension, idiopathic peripheral autonomic neuropathy (damage of the peripheral nerves where a cause cannot be determined), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). R36's Clinical Orders report printed 4/17/24, indicated an order dated 8/1/22 for a Prevalon boot (a therapuetic boot which helps reduce the	F 686	and Treatment policy was reviewed and remains current. All nurses were re-educated on the Pressure Injury Prevention and Treatment policy. Reoccurrence will be prevented by: Random observational audits will be conducted to ensure the quality of care related to personal devices is followed. 3 random audits will be completed weekly for 4 weeks, then 2 random audits for observational audits will be completed weekly for 4 weeks. The results of the audits will be brought to the QAPI committee meeting for review and further interventions as necessary. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.		

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F 686	Continued From page 16 risk of pressure wounds by keeping the heel floated and relieving pressure) for the left foot when on a recliner or in bed, every shift. R36's treatment administration record (TAR) between January and April 2024 included the order for the Prevalon boot. R36's care plan lacked documentation of the direction to use the Prevalon boot on the left foot. R36's medical record lacked documentation of refusal to use the boot. R36's nurse practitioner's visit report dated 3/18/24, indicated R36 had a history of peripheral artery disease with a left toe amputation and recurrent ulcers to bilateral heels. The provider also indicated R36 remained at a high risk for recurrent skin issues related to her diagnosis of peripheral vascular disease. During observation and interview on 4/16/24 at 9:50 a.m., R36 stated "once I had pressure wounds on my heels, they were open and took a long while to heal." When R36 removed her socks, her heels showed dry, soft, scaly, pink skin. R36 used her thumb to pressure her heels and she exclaimed "ouch." R36 stated her heels hurt if she puts pressure on them while in bed to reposition herself and when she stands up. R36 appeared confused when asked about the order to use a Prevalon boot on the left foot. R36 stated "I haven't used boots for a long time." During observation on 4/17/24 at 8:51 a.m., R36 was sitting on recliner chair and was not wearing a pressure relief boot on her left foot. R36 treatment administration record (TAR) dated 4/17/24 documented R36 was wearing the			F 686			

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F 686	Continued From page 17 Prevalon boot. During interview on 4/17/24 at 10:40 a.m., R36's spouse/family member (FM)-D stated R36 had not used a boot for at least four months, FM-D added "I visited her almost daily, so I know." FM-D looked around the room in drawers, cabinets, bathroom, and found the Prevalon boot in the back of an armoire drawer. FM-D stated the armoire was rarely used. During interview on 4/17/24 at 2:05 p.m., licensed practical nurse (LPN)-B stated R36 used a Prevalon boot when she sat on the recliner and laid in bed to prevent pressure areas on her heels. LPN-B stated she put the boot on when she returned to her room from breakfast and lunch. During observation and interview on 4/17/24 at 2:07 p.m. R36 was sitting in her recliner chair with her feet elevated and was not wearing a boot on her left foot. LPN-B asked R36, "why did you remove your boot?", R36, responded back, "What boot?" R36 firmly stated she had not removed a boot. LPN-B asked R36, "where is the boot?", LPN-B looked around the room and was unable to find the boot. After a few minutes LPN-B stated, "I probably confused R36 with another resident, you caught me, I did not put on the boot and signed for it (TAR)." During interview on 4/18/24 at 9:37 a.m. director of nursing (DON) stated the nursing staff failed to implement the Prevalon boot order and incorrectly documented what they were not doing and the resident was at risk for injury due to her history of pressure areas.	F 686			

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F 686	Continued From page 18	F 686			
F 688 SS=D	Facility's policy titled Prevention and Treatment of Pressure Injury dated 12/6/22, indicated it's their policy to properly identify and review residents whose clinical conditions increase the risk for development of skin issues and pressure injury, to implement preventative measures, and to provide appropriate treatment measures for pressure injury. Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess after repeated refusals of an ambulation program and, if needed, develop interventions to reduce the risk of mobility loss for 1 of 1 resident (R36) reviewed for mobility.	F 688			5/28/24
			Corrective Action: Resident R36 got an order to start OT/PT, and will be re-assessed for a walking program. Corrective Action as it applies to other residents: The Change of Condition policy and Restorative Nursing Policy was		

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F 688	Continued From page 19 Finding include: R36's annual Minimum Data Set dated (MDS) 4/8/24, indicated R36 had moderate cognitive impairment, no delirium, or behaviors, and did not refuse cares. MDS indicated, R36 needed moderate assistance with upper body dressing, toileting, oral hygiene, and bathing. R36 needed maximal assistance with lower body dressing, putting on/taking off footwear, personal hygiene, and transfers. MDS also indicated, R36 was at risk to develop pressure areas. R36's Clinical Diagnosis Report printed 4/17/24 indicated diagnoses of type II diabetes mellitus (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), diabetes chronic kidney disease (means a gradual loss of kidney function), vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), morbid obesity (a disorder involving excessive body fat that increases the risk of health problems), history of transient ischemic attack (temporary period of symptoms similar to those of a stroke that usually lasts a few minutes and doesn't cause permanent damage), dysphagia (difficulty swallowing), bunion left and right foot (a bony bump that forms on the joint at the base of the big toe) , hypertension, idiopathic peripheral autonomic neuropathy (damage of the peripheral nerves where cause cannot be determined), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood	F 688	reviewed and remains current. The nursing staff was re-educated on the change of condition policy. Reoccurrence will be prevented by: Random observational audits will be conducted to ensure that refusals of care are reported and followed up on. 3 random audits will be completed weekly for 4 weeks, then 2 random audits for observational audits will be completed weekly for 4 weeks. The results of the audits will be brought to the QAPI committee meeting for review and further discussion. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.		

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F 688	Continued From page 20 flow to the limbs). R36's mobility care plan printed 4/17/24 indicated, "Walking program #1: Walk with assist of 1 using a four wheeled walker daily. Can walk 100-200 feet. R36 can walk with her husband assisting and w/c [wheelchair] follow on the unit. Always use a transfer/chair belt when walking with R36." Intervention was initiated on 6/9/23, no revisions were docuemented to walking program since 6/2023. During observation and interview on 4/17/24 at 9:50 a.m., R36 stated that she can walk short distances in her room with her walker and assistance of one person. R36 stated staff have not offered to help her walk for a long time but she walked sometimes with the therapist, usually in the mornings. During interview on 4/18/24 at 8:23 a.m., nursing assistant (NA)-G stated he used to ask R36 if she wanted to walk after breakfast, R36 always responded she was tired or to try later. NA-G stated the nurses and manager knew R36 was not walking. During interview on 4/18/24 at 8:41 a.m., NA-H stated R36 was supposed to walk with the physical therapist before breakfast, but she wasn't sure why she was not walking to meals anymore. During interview on 4/18/24 at 8:56 a.m., registered nurse (RN)-K stated she worked on-call for several years and she had never seen R36 doing her walking program. During interview and document review on 4/18/24	F 688			

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F 688	Continued From page 21 at 9:00 a.m., RN-J, verified R36 had a Restorative Walking Program based on a therapist recommendation and it needed to be done. RN-J reviewed R36's care plan and noted the Restorative Program was not linked to the nursing assistants Kardex (resident's care directions used by nursing assistants). Instead, it had been linked directly to R36's electronic record under "tasks." RN-J reviewed the task documentation and noted the staff had documented R36 did not participate in the ambulation program in the months of January, February, March, or April 2024. The TAR for those months indicated R36 refused to ambulate or was not available. RN-J indicated this was very concerning because resident was supposed to be walking 100 to 200 feet and this could be an indication of decline and the walking program was no longer appropriate and needed to be re-evaluated. During interview on 4/18/24 at 9:26 a.m. director of nursing (DON) stated "R36's husband had been through a lot and maybe R36 didn't want to walk." DON stated she would send a message to the nurse manager to follow up. DON stated the rehabilitation programs were reviewed quarterly by the MDS coordinator, unit managers, administrator, Medicare nurse and DON. Their last meeting was in February 2024. DON stated R36 will need to be re-evaluated if she had not participated in the walking program. During interview on 4/18/24 at 10:20 a.m. physical therapist (PT)-A stated R36 received physical therapy services in 2023. In June of 2023, R36 was discharged and was placed on a nursing restorative ambulation program. PT-A stated R36 was currently on a physical therapy	F 688			

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F 688	Continued From page 22 skill maintenance program, three times a week. PT-A stated that a decline was expected due to her "Parkinson's condition like symptoms". PT-A added R36's walking distance had decreased from 100-200 feet to 50-80 feet. Her strength had declined, and the shuffling incidences had increased. PT-A stated she was not informed R36 had not been participating in the restorative nursing program with the nursing staff. During interview on 4/18/24 at 12:25 p.m. PT-A stated she would expect to be informed if a resident had stopped participating in a restorative program and expected to see a referral to re-evaluate the resident and develop a new restorative nursing program. DON provided a copy of the February 15th, 2024, Walking Programs LTC [Long Term Care] minutes which indicated R36's program was reviewed and it was decided her program was appropriate. Facility's policy title Restorative Nursing Program dated 10/2021 indicated "the purpose is that resident's ability in abilities in ADL's did not deteriorate and residents maintain their highest practicable well-being. This is a nursing program ordered by nurses with {physical; Occupational or Speech Therapy functioning as consultants".	F 688			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689			5/28/24

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F 689	Continued From page 23 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the use of bilateral, bed-mounted grab bars was comprehensively reassessed and, if needed, develop interventions to ensure safety while in bed for 1 of 1 resident (R62) reviewed who developed seizures after admission to the care center. Findings include: R62's admission Minimum Data Set (MDS), dated 4/1/24, identified R62 had intact cognition, demonstrated no delusional thinking during the review period, and required supervision or touch-level assistance with mobility-related activities of daily living (ADLs; i.e., rolling left to right, lying to sitting). Further, the MDS outlined a section labeled, "Section I - Active Diagnoses," with R62 being recorded as not having a seizure disorder or epilepsy. R62's most recent Device Assessment and Consent - V2, dated 3/26/24, identified an admission evaluation was being completed for two devices which included, "9. Grab Bars - Bilateral." The evaluation outlined R62 was not prevented from rising with them (i.e., restraint) but lacked any recorded alternatives attempted prior with the field to record such left blank and uncompleted. An intent of the device was listed to enhance positioning and/or independence with consideration being outlined as, "12. Recent trauma or surgery," and, "22. Wound," listed. A	F 689	Corrective Action: R62 grab bars were assessed with the Device/Consent Agreement assessment, care plan was reviewed and current. Corrective Action as it applies to other residents: The Seizure policy was reviewed and revised to add the Device/Consent Agreement assessment. The nursing staff was re-educated on the Seizure policy. Reoccurrence will be prevented by: All residents with a seizure diagnosis will have their care plan updated and ensure a current Device/Consent Agreement assessment is present. Observational audits will be conducted to ensure that Device/Consent Agreement assessments and consent when/if a resident has a seizure. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.		

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F 689	Continued From page 24 series of potential risks were identified and the evaluation concluded with a section labeled, "B. Consent for Device(s)," which outlined R62 consented to using them on 3/26/24. The evaluation included a checkmark placed next to, "1. Care Plan Current." The completed evaluation lacked evidence R62 was identified with any current or history of seizures. R62's ADL care plan, dated 3/27/24, identified R62 had an ADL self-care deficit and listed several interventions for R62 including, "Bilateral grab bars." The care plan contained a section on the top labeled, "Special Instructions," which identified, "SEIZURE PRECAUTIONS; OK to administer oral medications in public places." On 4/8/24, the care plan was updated to include, "[R62] has a seizure disorder," with several interventions including asking R62 about potential aura prior to events and giving medications. However, the care plan lacked any specific information on what, if any, interventions were considered or needed to promote safety while in bed despite use of bilateral grab bars and associated risk of injury. R62's progress notes, dated 3/26/24 to 4/15/24, were reviewed and identified: On 3/26/24, R62 admitted to the care center from the hospital after having a right shoulder dislocation. R62 was listed as, " ... alert [and] oriented X4." On 4/3/24, R62 was found to have had an emesis and complained of 'not feeling well.' R62's vital signs were within normal limits and she was brought to her bed to rest after bowel medication was given.			F 689			

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F 689	Continued From page 25 On 4/4/24, R62 continued with shoulder pain and was listed as alert and oriented. The note included a section labeled, "Safety," which identified the call light was in reach and added, "Resident is not on seizure precautions." On 4/5/24, R62 was with therapy when they reported, " ... patient having a seizure like activity during session ... increase in tremors to UE [upper extremities] spacing/eye glaze, uncommunicative for approximately 15-20 seconds ... she [R62] stated that she 'probably' had a seizure ... explained that she has a PMH [past medical history] of epilepsy." The note outlined R62, "Patient currently is in her room, sitting up in her bed ... IDT [interdisciplinary team] and NP [medical provider] updated." On 4/8/24, R62 had a witnessed seizure while in the dining room. The note outlined, " ... [R62] reported to nurse in dining room that she wanted to get back to her room fast because she was going to have seizure ... began to have tremorsand [sic] was sat back into chair ... Seizure lasted approx. 2.5 mins; [R62] was able to track staff [with] eyes, but was unresponsive; upper bilateral extremities convulsing noted ... began drooling during seizure ... broughtto [sic] room following ... also had x2 emesis in room following seizure ..." A subsequent note, also dated 4/8/24, identified R62 declined transfer to the hospital following the seizure. However, none of the completed progress notes identified any re-evaluation of R62's use of bilateral grab bars, including potential safety interventions to reduce the risk of injury within the bed environment, despite now having sustained	F 689			

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F 689	Continued From page 26 multiple seizures at the care center. On 4/15/24 at 6:34 p.m., R62 was observed seated on her bed while in her room with a black-colored sling on her right arm. R62's bed was positioned against the far-wall of the room and had bilateral, white-colored metal u-shaped grab bars attached to the frame of the bed. There was no visible padding on the devices. R62 was interviewed, and stated she had admitted to the care center after being in the hospital due to a "broken arm." When asked, R62 verified she had a history of seizures and expressed she had been "born with them," but they stopped until recently while at the care center when she had more of them. R62 was questioned on the bilateral grab bars and stated she used them often to help her stand up. However, upon touching the bar attached to the left side (open side) of the bed, it moved side to side several inches and was unsecured with only light touch being needed to move it. R62 stated it had been loosened due to her seizures adding the resulted shaking was "what loosened it." R62 stated it had been loose for "two weeks" or so and, to her recall, had not been inspected since the seizures started; nor had any staff discussed their ongoing use with her since, either. R62's entire medical record was reviewed and lacked evidence R62 was comprehensively reassessed for safety with use of bilateral, bed-mounted grab bars despite having multiple, witnessed seizures at the care center. There was no evidence what, if any, potential safety interventions were considered or evaluated (i.e., different type of bar, padding) to reduce the risk of injury should R62 sustain a seizure while in bed.			F 689			

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F 689	Continued From page 27 On 4/16/24 at 1:06 p.m., nursing assistant (NA)-B was interviewed. NA-B explained they had worked with R62 multiple times and described her as needing "just minimum" help with cares adding R62 was able to get up from her bed without physical assistance. NA-B verified R62 had metallic bilateral grab bars without any padding present and stated she used them "to stand up" on her own with no complaints of them being voiced from R62. NA-B then touched the left side bar, at the request of the surveyor, and verified it was loose adding, "uh oh." NA-B stated R62 must have been "using [it] too much." Further, NA-B stated they recalled hearing R62 had sustained seizures after she admitted to the care center and expressed, to their recall, the nurses' were aware of it. When interviewed on 4/16/24 at 1:13 p.m., licensed practical nurse (LPN)-A explained side rails and grab bars were evaluated upon admission to ensure safety by nursing and, if needed, physical therapy. LPN-A stated the results were documented using the Device Assessment and Consent form to their knowledge adding, "I think so." LPN-A verified R62 had sustained multiple seizures after she admitted to the care center and expressed "the charge nurse or the manager" would be responsible to re-evaluate the use of physical devices, such as grab bars, if needed. LPN-A stated they had not been told or directed to do any special monitoring or interventions while R62 is in bed (i.e., padding, safety checks) with the bare metal bars attached adding they were "not sure" if the devices had been re-evaluated or not. On 4/16/24 at 2:10 p.m., the environmental	F 689			

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F 689	Continued From page 28 services director (ESD) was interviewed. They explained the care center used two types of grab bars which mounted to the bed frames and were checked for fit on a monthly basis. ESD observed R62's bed and grab bars and verified they were a "Invacare" brand adding padding for them was available, if needed. However, application of such would only be done if initiated by nursing adding, "We can't make that call." On 4/16/24 at 3:03 p.m., registered nurse unit manager (RN)-E was interviewed and verified they had reviewed R62's medical record. RN-E explained grab bar use' was evaluated upon admission and then via the MDS cycle thereafter (i.e., re-admit, quarterly). RN-E stated re-evaluation of the devices' would not typically be done after a resident, including R62, developed seizures. RN-E verified the care center was unaware R62 had a history of seizures upon admission as there was no mention of it within the hospital' paperwork. RN-E verified the medical record lacked evidence R62's use of bilateral metal grab bars, including for any potential safety interventions with them, had been re-evaluated since she had seizures and reiterated it would not be done until the next MDS was due for completion. However, RN-E stated it was important to ensure their use was periodically reviewed to "make them safer" and reduce the risk of injury to the resident. A facility' provided Seizure Precautions policy, dated 11/23, identified a purpose to prevent injury and implement emergency care to a resident with seizures. A procedure was listed which included how to address an active seizure, however, lacked any information or dictation on post-seizure physical device (i.e., side rails, grab	F 689			

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F 689	Continued From page 29 bars) use re-evaluation. However, a provided Assessment and Use of Grab Bars/Side Rails policy, dated 3/24, identified a policy outline which read, "Upon admission and ongoing the nurse/IDT will assess the need and safety of grab bars or side rails ... The nurse will document these conversations and recommendations."			F 689			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff provided cares according to standard of practice for gastrostomy tube care for 1 of 1 residents (R230)			F 693	Corrective Action: R230 received new dated graduate and syringe and has been labeled and dated.		5/28/24

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F 693	Continued From page 30 reviewed for tube feedings. Findings include: R230's admission Minimum Data Set (MDS) dated 2/28/24, identified R230 "dependent on helper (staff) for all effort of activity or requires assistance of 2 or more helpers for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, personal hygiene and mobility." In addition, R230 diagnoses included stroke (cell death to portions of the brain causing loss of functioning), aphasia (inability to speak well), hemiplegia/hemiparesis (partial paralysis) of right dominant side, respiratory failure, dysphagia (inability to swallow), and had a gastrostomy tube (feeding tube to stomach) for all nutrition and medication administration. R230's care plan (CP) dated 2/23/24, documented R230 "Dependent with tube feeding and water flushes". And "Enteral feed: Water flushes via PEG tube [feeding tube inserted in abdomen] of 120 milliliters [mL] every [q] 4 hours [hrs] + 90 mL before and after feeds. Water flushes + free water from formula = 1964 mL free water daily." During observation on 4/15/24 at 1:37 p.m., R230 was lying in bed with eyes closed. A graduated cylinder with 400 mL of clear fluid and a piston syringe was resting inside was noted to be on a rolling bedside table next to R230. The graduated cylinder and piston syringe did not have a date or label. During observation on 4/16/24 at 8:19 a.m., an empty undated and unlabeled graduated cylinder and piston syringe resting inside, was observed to	F 693	Corrective Action as it applies to other residents: The Enteral Feeding Tube Care policy was reviewed and revised that the syringe and graduate are replaced daily and dated. Nursing staff will be re-educated on the The Enteral Feeding Tube Care policy. Reoccurrence will be prevented by: Random observational audits will be conducted to ensure that residents with g-tube have the appropriate dated supplies. 3 random audits will be completed weekly for 4 weeks, then 2 random audits for observational audits will be completed weekly for 4 weeks. The results of the audits will be brought to the QAPI committee meeting for review and further discussion. The Correction will be monitored by: The Unit Managers and Director of Nursing or Designee.		

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F 693	Continued From page 31 be on the rolling bed side table next to R230. During interview with registered nurse (RN)-A on 4/16/24 at 8:21 a.m., RN-A pointed to graduated cylinder and piston syringe in R230's room and stated, "it is not labeled [and dated]". During observation on 5/17/24 at 8:05 a.m., an empty undated and unlabeled graduated cylinder and with piston syringe resting inside, was observed to be on R230's dresser near the foot of bed. During observation on 5/18/24 at 8:13 a.m., in R230's bathroom on the counter next to sink, an empty undated and unlabeled graduated cylinder and piston syringe were observed sitting on a paper towel with piston syringe laying next to the graduated cylinder. During interview with RN-F on 4/18/24 at 8:26 a.m., RN-F stated, "Syringe and container is changed every 24 hours. Night shift does it. It must be dated and labeled. No, I do not see a date or label on the syringe or container. I used [graduated cylinder and piston syringe] this morning [for R230's medication administration and tube flushing]." And "I should not use it because that is not a good professional practice to use a non-dated and labeled syringe and container. I honestly would not know when it was actually replaced. It could be one day or several days." RN-F stated the practice is a, "concern for infection control in a immunosuppressed gentleman". RN-F pointed to R230's electronic medical record (EMR) and stated it lacked a care plan or treatment record of documenting when and if the equipment replacement was done.	F 693			

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F 693	Continued From page 32 During interview with infection control (IP) on 4/18/24 at 11:50 a.m., IP stated, for medical equipment including the graduated cylinder and piston syringe for R230's gastrostomy care, "they should be dated on a weekly schedule. Even if it were documented in the EMR we would expect [both containers to be dated and labeled]." During interview with director of nursing (DON) on 4/18/24 at 12:11 p.m., DON stated, for medical equipment including the graduated cylinder and piston syringe for R230's gastrostomy care, "The graduated cylinder and syringe must be dated. If it is not dated then there is a concern with infection control because we don't really know when it was changed or replaced. Even if staff document in the electronic medical record (EMR) that it is changed, standard practice is to not use the syringe or container because we cannot be sure when it really was changed." DON stated facility did not have process to ensure the dating and labeling of tube feeding equipment was documented in the EMR or audited for compliance.	F 693			
F 761 SS=E	Facility policy titled INTERNAL [SIC] FEEDING TUBE-CARE OF revised 10/21 direct staff to, "8. Replace and date syringe every 24 hours". Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761			5/28/24

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F 761	Continued From page 33 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure two medication carts were kept locked or under direct observation of authorized staff in areas where residents, staff and guests could access medications. The deficient practice had the potential to affect twenty residents that resided on those units. Findings include: Facility map provided to surveyors immediately after entrance on 4/15/24 identified the Bridgeway unit of facility as the Transitional Care Unit (TCU) of the facility. This includes rooms 110-129. During observation on 4/16/24 at 8:19 a.m., an unattended medication cart in the west section of the TCU was observed to be unlocked with no staff visible. During interview with registered	F 761	F761 Label/Store Drugs and Biologicals Corrective Action: Medication carts were locked and staff were educated on the spot in events of open medication carts without staff personnel present. Corrective Action as it applies to other residents: The Medication Storage policy was reviewed and remains current. Nursing staff will be re-educated on the Medication Storage policy. 3 random audits will be conducted weekly to ensure proper locking of medication carts for a minimum of 6 weeks. The Quality Assurance Performance Improvement (QAPI) committee will monitor audits and will determine when to phase out audits based on 100% compliance.		

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F 761	Continued From page 34 nurse (RN)-A on 4/16/21 at 8:21 a.m., RN-A stated he was responsible for the unlocked unattended medication cart. RN-A stated, "when I leave med cart I should hide the resident info on the laptop and lock med cart." During interview with charge nurse, RN-C on 4/17/24 at 8:08 a.m., RN-C stated, "When you leave [it], med cart is to be locked and screen locked for patient privacy." RN-C provided surveyor a list of residents the medication cart for RN-A was responsible for. This list titled Team 4 Nurses Census Sheet includes ten residents of the TCU. During observation and interview with licensed practical nurse (LPN)-A on 4/16/24 at 9:15 a.m., an unattended unlocked medication cart in the east section of the TCU and directly next to a resident lounge and nursing station, was observed near two residents who were in the lounge and a housekeeper with her cart passing by it. No nursing staff was observed in vicinity at the time. At 9:18 a.m., LPN-A approached the unattended unlocked medication cart and stated she was responsible for the medication cart. LPN-A stated, "yes my cart is unlocked. [It] should be locked so the meds are not accessible to everybody." RN-F provided surveyor a list of residents the medication cart for LPN-A was responsible for. This list titled Team 2 Nurses Census Sheet includes ten residents of the TCU. During interview with RN-F on 4/18/24 at 8:26 a.m., RN-F stated, "any time I leave the med cart, I turn screen off of [sic] computer with any kind of patient information shown and lock the cart. [It is] important for patient privacy."	F 761			

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F 761	Continued From page 35 During interview with director of nursing (DON) on 4/18/24 at 12:11 p.m., DON stated, "med carts should always be locked when leaving cart to secure medications." And, [unlocked med carts] are a,"safety issue" with unrestricted access to resident medications. Facility policy titled Medication Administration-General Guidelines with review date of 3/10/23, direct legally authorized persons, "During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or trained medication aide."	F 761			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812			5/28/24

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F 812	Continued From page 36 Based on observation, interview and document review, the facility failed to ensure expired and visibly molding produce was disposed to prevent serving expired food. This had potential to affect all residents, visitors and staff who consumed food from the main kitchen. Findings include: During the initial kitchen tour with the dietary director (DD) on 4/15/24 at 12:10 p.m., the walk-in cooler was observed, which stored food served to all units of the facility and contained the following expired foods; an unopened bag of broccoli with a use-by date of 3/18/24, which was noticeably watery with brown spots, four unopened five-pound bags of brussels sprouts with a use-by date of 2/28/24, a cardboard box with approximately 25 cucumbers with noticeable denting open areas and white colored mold, a cardboard box 1/4 full of wrinkled, drooping asparagus with a use-by date of 3/22/24, three unopened bags of pre-chopped zucchini with a use-by date of 4/2/24 which was noticeably watery and browning, and two undated bags of precut potatoes which appeared watery with white mold spots. During an interview on 4/17/24 at 1:09 p.m., the DD confirmed there was expired produce on the back shelf in the walk-in cooler and that it was disposed of after the initial kitchen tour. The DD stated all fresh produce is delivered on Tuesdays and Fridays and they would expect fresh produce to be disposed of seven days after delivery, when it was past the used by date or appeared "old" in anyway. The DD stated most of the produce was delivered with a use by date, but it would be expected for all produce to be dated when			F 812	All expired food products were removed and discarded from the walk-in coolers and dry storage immediately. The Food Storage and Sanitation policy was reviewed, no revisions made. The Culinary Director, supervisor, and culinary department will receive re-education on Food Storage Policy. Audits will be completed twice weekly for eight weeks, the audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to determine if further interventions need to be placed to ensure compliance. The Culinary Director or Designee is responsible for ensuring compliance.		

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F 812	Continued From page 37 opened. During a follow up interview on 4/18/24 at 8:32 a.m., the DD stated they threw away enough produce to feed all the residents at the facility for at least one meal. The DD stated he would be concerned about the produce being served as it would put the residents at risk of getting sick. Review of the facilities "Week 3" menu, dated 4/15/24, indicated chicken zucchini was on the lunch menu for Monday, 4/15/24 and broccoli was on the menu to be served for dinner on Monday, 4/15/24. A facility policy titled Food Safety, revised 3/2019, indicated the director of food and nutrition services would be responsible for providing safe foods to all residents and to ensure all refrigerated foods were stored and handled properly.	F 812			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880			5/28/24

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F 880	Continued From page 38 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents			F 880			

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F 880	Continued From page 39 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure appropriate infection control measures were implemented for direct resident care for 1 of 1 residents (R230) who was placed on enhanced barrier precautions. In addition, the facility failed to ensure clean personal and facility laundry was protected during transport and storage outside resident rooms. This had the potential to affect all 132 residents who utilized facility provided laundry services. Findings include: PPE Use The Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality/Quality, Safety and Oversight Group Ref: QSO-24-08-NH dated March 20, 2024, state ""Enhanced Barrier Precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities." In addition, "EBP are indicated for residents with any of the following:			F 880	Corrective Action: Staff working with R230 were re-educated on the enhanced barrier precaution guidelines including RN-A, Covers were purchased and implemented for laundry carts transporting personal clothing. Corrective Action as it applies to other residents: The Enhanced Barrier Precautions policy was reviewed and remains current. The Handling Linen policy was reviewed and revised. All staff will be re-educated on the Enhanced Barrier Precautions policy. Nursing and laundry staff will be educated on the Linen Handling policy. Reoccurrence will be prevented by: Random observational audits will be conducted to ensure that the correct PPE is worn in rooms requiring Enhanced Barrier Precautions. 3 random audits will be completed weekly for 4 weeks, then 2 random audits for observational audits will be completed weekly for 4 weeks. The		

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F 880	Continued From page 40 -Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or -Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO." Also, "Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies." Guidance also state, "EBP is employed when performing the following high-contact resident care activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing". R230's admissions Minimum Data Set (MDS) dated 2/28/24, documented R230 "dependent on helper (staff) for all effort of activity or requires assistance of 2 or more helpers for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, personal hygiene and mobility." In addition, R230 was listed with diagnoses which included stroke (cell death to portions of the brain causing loss of functioning), aphasia (inability to speak well), hemiplegia/hemiparesis (partial paralysis) of right dominant side, respiratory failure, dysphagia (inability to swallow), and had a gastrostomy tube (feeding tube) for all nutrition and medication administration. R230's care plan (CP) dated 2/23/24, directed staff to the following, "PERSONAL HYGIENE/ORAL CARE: (1) staff assist with personal hygiene/oral care. Oral cares with oral sponge every 2-3 hours while awake. Oral Cares:	F 880	results of the audits will be brought to the QAPI committee meeting for review and further discussion. Reoccurrence will be prevented by: Random observational audits will be conducted to ensure that the correct coverings on the personal and facility laundry. 3 random audits will be completed weekly for 4 weeks, then 2 random audits for observational audits will be completed weekly for 2 weeks. The results of the audits will be brought to the QAPI committee meeting for review and further discussion. The Correction will be monitored by: The Infection Preventionist and Director of Nursing or Designee.		

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F 880	Continued From page 41 Wet toothbrush with mouthwash and brush teeth." CP dated 2/23/24 documented, "Requires tube feeding related to Dysphagia" and on 3/29/24 "Enhanced Barrier Precautions due to indwelling device". CP dated 4/8/24 indicated, "Enhanced Barrier Precautions Indefinitely due to Indwelling device." Interventions/Tasks included: "REQUIRED PPE: Gloves and gown prior to the high-contact care activity: High-contact resident care activities such as but not limited to: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and Wound care: any skin opening requiring a dressing". During observation on 4/15/24 at 12:39 p.m., door frame of R230's room had signage posted for enhanced barrier precautions with instructions for staff and visitors regarding when to wear PPE when caring for R230. Also, a personal protective equipment (PPE) cart was located outside the room. During observation on 4/16/24 at 8:19 a.m., registered nurse (RN)-A exited R230's room wearing gloves and walked to supply cabinet in the hallway and opened the cabinet (still wearing gloves) to obtain a toothette oral swab. Then RN-A closed the cabinet door (with gloved right hand) and walked back into R230's room without changing gloves, sanitizing hands, or putting on a PPE gown. RN-A again walked back out to the hallway and repeated actions (walking to the cabinet with gloved hands, opening the cabinet, obtaining oral toothette, closing the cabinet with gloved right hand, and re-entered R230's room without changing gloves, sanitizing hands, or	F 880			

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F 880	Continued From page 42 putting on a PPE gown.) RN-A walked to resident who was lying in bed and provided oral care using toothettes moistenend with water (dipping toothette in water and inserting toothette into mouth and rubbing along the oral cavity, including teeth and gums). RN-A then disposed of the toothettes into the trash and removed gloves and exited room without sanitizing hands. During interview with RN-A on 4/16/24 at 8:21 a.m., RN-A stated R230 was on EBP because, "he [R230] has tube feeding" and RN-A stated he was providing oral cares for R230 using the oral toothettes and "needed to get supplies" which is why he left the room twice to obtain them in the supply cabinet. RN-A stated, "I need to wear gown [PPE] when I am using toothettes with [R230]. I did not do that." Also, "[I] should wear gown and gloves" when providing direct personal care. And, RN-A stated he did not sanitize hands upon entering and exiting R230 room. During interview with RN-B on 4/16/24 at 1:35 p.m., RN-B stated residents on EBP require staff to "wear gown and gloves when direct patient care: touching them". Also, RN-B stated, "we must sanitize our hands [before and after resident care]." During interview with RN-G on 4/18/24 at 8:26 a.m., RN-G stated residents with rooms posted with EBP signage directed staff , "to protect them [residents]" and using a toothette is considered "direct patient care" and "we [staff] must wear gown and gloves [when providing direct patient care]". During interview with director of nursing (DON) on 4/18/24 at 12:11 p.m., DON stated, "staff should	F 880			

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F 880	Continued From page 43 always sanitize hands before and after being an a EBP room. Staff must wear PPE gown and gloves when providing direct care like using a toothettes to clean [R230] mouth." Clean linen transport During observation on 4/16/24 at 9:07 a.m., staff observed to be pushing a four wheeled laundry cart down the hall on the first floor of facility through the transitional care unit (TCU) with the top completely off. White linen was visible as cart was pushed past rooms 100-111. During observation on 4/16/24 at 9:15 a.m., a covered a four wheeled laundry cart was observed outside R37's room. Signage on door frame of R37's room indicated Contact Precautions and instructions for staff and visitors when to don and doff PPE's. A fabric gown was lying on top of the closed cart. During interview with licensed practical nurse (LPN)-A on 4/16/24 at 9:19 a.m., LPN-A stated the four wheeled laundry cart was for "clean laundry in there. The fabric gown should not be on top of clean linen cart because of [concern for] infection control." During observation on 4/17/24 at 8:06 a.m., a four wheeled laundry cart outside R84 and R37's rooms with top of cart open and visible laundry inside of it was observed. During observation and interview on 4/17/24 at 8:08 a.m., a four wheeled laundry cart outside R77's room with top of cart open and visible laundry inside of it. RN-C stated the linen carts contained clean PPE fabric gowns and, "for best	F 880			

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F 880	Continued From page 44 practice they should be covered [at all times]. [And] nothing should be on top of them." During observation on 4/17/24 at 8:31 a.m., a four wheeled laundry cart with a fabric gown on top of it was observed in the long term care unit (LTC) of "Fox Crossing" hallway. During observation on 4/17/24 at 12:35 p.m., a four wheeled laundry cart with top of cart half-way open with visible laundry inside of it and a fabric gown placed on top of it was observed in the TCU, "Bridgeway" hallway. During observation on 4/17/24 at 12:39 p.m., a separate four wheeled laundry cart with top of cart open with visible laundry inside was observed in the TCU, "Bridgeway" hallway. During observation on 4/17/24 at 12:45 p.m., a four wheeled laundry cart with top of cart open with visible laundry inside was observed in the TCU, "Bridgeway" hallway. During observation on 4/17/24 at 1:44 p.m., a four wheeled laundry cart was observed outside R77's room with top of cart open and visible laundry inside of it. During observation on 4/18/24 at 1:26 p.m., a four wheeled laundry cart was observed with top of cart open and visible laundry inside of it in the LTC of "Eagle Crest" hallway for rooms 200-211. During observation on 4/18/24 at 1:26 p.m., a four wheeled laundry cart was observed with top of cart open and visible laundry inside of it in the LTC of "Eagle Crest" hallway for rooms 212-223.			F 880			

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F 880	Continued From page 45 During observation on 4/18/24 at 1:33 p.m., a four wheeled laundry cart was observed with top of cart open and visible laundry inside of it in the locked memory care unit of facility, "Prairie Spirit" hallway. During observation on 4/18/24 at 1:27 p.m., a four wheeled laundry cart was observed with top of cart open and visible laundry inside of it in the LTC "Fox Crossing" hallway. During interview with IP on 4/18/24 at 11:50 a.m., IP stated clean linen carts located outside resident rooms contain fabric washable PPE gowns that are used for staff who enter resident rooms that are on precautions (EBP, Standard, Contact, Isolation). IP stated, "I don't want them open [clean linen carts] to protect them. They should be covered." Personal Linen During observation on 4/16/24 08:27 a.m., an uncovered metal laundry cart delivering personal laundry items was observed on 1st floor in Fox Crossing. The cart had residents clean personal items on it (both hanging on the metal bar from hangers and on the shelves where folded items sit). It was observed as the cart was pushed down the hallway, the clean personal laundry items were touching/rubbing again the walls and handrails. During interview at this time, laundry aid (LA)-E stated, "we don't have covers for these carts, only for the linen carts." On 4/16/24 at 8:47 a.m., a four-tiered metal open and uncovered laundry cart was observed on second floor that appeared to be used for	F 880			

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F 880	Continued From page 46 personal laundry items. The cart was empty, had 2 metal bars with hangers on it with white circle separators with room numbers written on them. The other half of the cart had 4 shelves, some of the shelves had slots. There was no cover on or around the cart. On 4/17/24 at 7:36 a.m., LA-E verified they have worked in laundry for over 10 years. They verified they have 3 metal carts that deliver personal laundry to the facility. Each of the laundry carts have a place to hang personal items on hangers, separated by white circle rings with rooms numbers on them. The other half of the carts have shelves on them for personal items that are folded for resident drawers. LA-E verified the 3 carts used to deliver the personal laundry items for residents are not covered. LA-E stated, "personal clothing has never been covered." LA-E stated, "clean linen is covered so it doesn't get dusty and dirty." LA-E stated they do "pretty much" everyone's laundry in the facility. On 4/17/24 at 7:43 a.m., LA-D verified they have worked in laundry for over 10 years. LA-D stated that "we have never covered the personal laundry" and added "maybe it is because "we bring it up right away and deliver it." LA-D verified they cover the clean linen and not personal laundry. On 4/17/24 at 11:01 a.m., infection preventionist (IP) verified that she oversees the infection prevention program for the facility. IP verified clean linen carts are covered to "to keep residents from throwing stuff in there and keep them clean as so many things can come in contact with it." When IP was asked about keeping personal linen covered, she stated, "I	F 880			

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F 880	Continued From page 47 don't know that if I can answer that one specifically and would direct you to their department head." On 4/18/24 at 9:30 a.m., director of environmental services (ESD)-A verified that he oversees the laundry. ESD-A verified clean linen carts are covered for multiple purposes including dignity, and infection control purposes. ESD-A verified clean personal laundry carts are not covered when delivered to the floors to residents. ESD-A verified "historically they have never been covered." ESD-A stated that he will get some covers ordered now that he is aware that they need to be covered. On 4/18/24 at 12:22 p.m. director of nursing (DON) stated "I don't know the policy on that" when asked about how should clean personal laundry be transported to resident rooms. Facility policy titled STANDARD PRECAUTIONS FOR INFECTION CONTROL/ENHANCED BARRIER PRECAUTIONS revised 4/1/24 directed health care workers to "perform hand hygiene according to the Hand Hygiene (Hand Washing) policy" and "Enhance Barrier Precautions (EBP) are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing." Also, policy stated, "When to use Enhance Barrier Precautions" include, "Feeding tubes" and "Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: -Dressing	F 880			

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F 880	Continued From page 48 -Bathing/showering -Transferring -Providing hygiene -Changing linens -Changing briefs or assisting with toileting -Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator -Wound care: any skin opening requiring a dressing." Facility policy titled Hand Hygiene revised 4/24 directed staff to, "Perform hand hygiene upon room entry and exit has been suggested as best practice to facilitate hand hygiene compliance." Additionally, "Do not wear gloves in hallway. Perform hand hygiene after doffing gloves and donning a new pair."	F 880			
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen floors and mats were routinely and properly cleaned to ensure a sanitary kitchen environment. This had the ability to affect all 132 residents residing at the facility.	F 921	The floors and mats were cleaned with a floor scrubber, unnecessary items were removed from the clean dish room. The Food Safety policy was reviewed and remains current. The Culinary Director, Supervisor, and kitchen staff will be re-educated on the Food Safety Policy.		5/28/24

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F 921	Continued From page 49 Findings include: During the initial kitchen tour on 4/15/24 at 12:10 p.m., the kitchen floors including the food preparation area, the walk-in cooler, the dry storage room, and the clean dishware storage room were noticeably soiled. The floors were covered sporadically with a white/brown coating, various old dried food particles filling the crevices of floor mats and sporadically covering the floor in all rooms including underneath food and clean dish storage racks, various used food wrappers such as used Café Delight and brown sugar topping packets, broken and scattered dishware pieces in the clean dishware room, as well as noticeably darkened and soiled mop heads found underneath food storage racks and in the food preparation area. During an interview on 4/17/24 at 1:09 p.m., the dietary director (DD) confirmed the dirty kitchen floors and mats during the initial kitchen tour, stating, "it was pretty bad." The DD stated they pulled up the mats the previous night and had the night custodian deep clean the floors. The DD stated they did not have a cleaning schedule established and would work with maintenance to get a schedule for cleaning the kitchen floors. The DD stated they were working on creating a formal cleaning schedule to include areas that were "frequently missed" including the floors and mats stating there was not a good cleaning process prior. During a follow up interview on 4/18/24 at 8:32 a.m., the DD stated they would be concerned about the dirty floors potentially causing food borne illness stating it was, "best to have things clean."	F 921	Routine cleaning schedules for kitchen floors and mats have been created. Audits to ensure cleaning schedules are followed will be completed two times per week for six weeks. Audit compliance will be reviewed by the Quality Assurance Performance Improvement (QAPI) committee to determine other interventions if necessary. The Culinary Director or designee is responsible for ensuring compliance.		

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F 921	Continued From page 50 A facility policy titled Food Safety, revised 3/2019, indicated the director of food and nutrition services would ensure sanitary conditions were maintained in storage, preparation and food serving areas and that cleaning schedules would be posted and followed.	F 921			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/17/2024. At the time of this survey, Martin Luther Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/06/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Martin Luther Care Center is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (000) construction. An addition, a 1-story, Type V (111) building was completed in 2010 and a 1-story, Type II (000) building was completed in 2011. The buildings will be surveyed as one building. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with	K 000			

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K 321	Continued From page 3 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, and 8.3.3.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 04/17/2024 at 11:27 AM, it was revealed by observation that the door to the soiled utility room in the basement did not positivity latch. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 321	The utility room door latch will be replaced. Other doors in the facility that require positive latching will be audited to ensure compliance with Regulation 0321 - NFPA 101. The Director of Environmental Services was re-educated on the requirements. The Environmental Services Director is responsible for ensuring compliance.		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,	K 324			5/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER MARTIN LUTHER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 EAST 100TH STREET BLOOMINGTON, MN 55425		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 324	Continued From page 4 or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/17/2024 between 09:30 AM and 12:15 PM, it was revealed by observation that the locked switches for the five residential stoves in the facility are not on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 324	The five residential stoves on the various unit have been serviced to timeout after 120 minutes of operation, this was completed on 4/24/2024. The Fire Safety Policy was reviewed and revised to include the stove timeout at 120 minutes. The Director of Environmental Services or Designee is responsible to ensure maintenance of residential stoves on unit are in compliance with regulation 0324 - NFPA 101.		