Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 3, 2024

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: CCN: 245148
Cycle Start Date: June 13, 2024

Dear Administrator:

On June 13, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 18, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 18, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 18, 2024.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 18, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At St Louis Park Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 18, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 13, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or

termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

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

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,

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

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July 3, 2024

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: W6M011

Dear Administrator:

The above facility was surveyed on June 10, 2024 through June 13, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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 6/10/24 to 6/13/24, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. The Estates at St Louis Park, LLC was found 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 6/10/24 to 6/13/24, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, complaint investigations were also completed. The Estates at St Louis Park, LLC 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: H51484388C (MN95247); non-compliance cited at F921. H51484386C (MN96373) H51484384C (MN97002) H51484382C (MN98204) H51484383C (MN98568) H51484385C (MN98693) H51484387C (MN98881) H51484389C (MN99241) H51484540C (MN103985); non-compliance cited at F600.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/08/2024

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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=E	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.	F 550		7/17/24

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F 550	Continued From page 2 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote a dignified environment for 3 or 4 residents (108, R2, R49) reviewed for resident rights. Findings include: R108's quarterly Minimum Data Set (MDS) assessment, dated 5/14/24, indicated R108 had severe cognitive impairment and required partial to moderate assistance with activities of daily living (except eating) and ambulation in the unit hallways. During observation on 6/12/24 at 7:00 a.m., R108 and seven other residents were seated out in the dining room. Four of the residents had coffee in front of them and four had empty juice and coffee cups sitting in front of them. No interaction was observed between staff and residents as staff was still getting residents up for the day.	F 550	F550 1.Resident R108 was given breakfast and was not affected by this practice. R108, R2 had labels on clothes removed and were not affected by this practice. R49 will have a new assessment completed which will include his preferences with activities. R49 was not affected by this practice. 2.All residents have the potential to be affected by this practice. Facility will review timing of meals to ensure residents are being served timely and all residents at the table are served at the same time. The housekeeping manager is reviewing clothes when they come down to laundry to ensure there are no labels on outside of clothing. Meal service window time will be shorted to ensure timeliness. 3 Education will be conducted with dietary	

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F 550	Continued From page 3 During an interview and observation on 6/12/24 at 7:31 a.m., clinical coordinator and licensed practical nurse (LPN)-D stated breakfast was not served until around 8:30 most days, which was a "long time for these residents to wait." During observation on 6/12/24 at 8:03 a.m., residents were still sitting in the dining area, a total of sixteen residents now, four residents with empty juice and coffee cups in front of them. One resident observed sitting at a table alone, with her forehead resting on the table. During observation on 6/12/24 at 8:10 a.m., there were eighteen residents out in the dining room, juice and coffee at the tables but no food at this time. Outside of the dining room was an empty sitting area with a television, one recliner, one love seat, one side chair and multiple dining room chairs and space for wheelchairs. During an interview on 6/12/24 at 8:12 a.m., certified nursing assistant (CNA)-J stated the process he followed was to get the residents who needed the most care up first and bring them out to sit in the dining room followed by residents who could ambulate on their own. CNA-J stated this order of getting residents up was for convenience to ensure they had enough time to get up all residents up before breakfast. During an interview and observation on 6/12/24 at 8:22 a.m., R108 stated she was still waiting on breakfast (was observed in the dining room since 7:00 a.m.), stating "I am hungry, hopefully soon." The residents in the dining room were becoming restless and loud as they were still waiting for breakfast, with residents who were ambulatory getting up and leaving the dining room area.	F 550	and licensed staff regarding ensuring each table is served together. Education will be provided to staff on ensuring residents are engaged and not left in the dining room if a meal is not ready to be served. Offer them to engage with other residents to socialize or another activity. Education will be conducted with staff to ensure clothes are never labeled on the outside of clothing items. Education will be conducted with staff on facilities policy regarding dignity and leaving residents in undignified situations, to include, being left in the dining room after a meal. 3.Five audits will be conducted weekly for 4 weeks. Then once weekly for 4 weeks. Audits will be conducted by NHA or designee. Audits will be brought to QAPI by NHA or designee to review trends.	

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F 550	Continued From page 4 During observation on 6/12/24 at 8:27 a.m., R108 was yelling out, "I am hungry!" from her seat at the table in the dining room. During observation on 6/12/24 at 8:35 a.m., a metal cart with breakfast trays was brought into the dining room and the first residents were served their breakfast. Residents at the same table were not served at the same, with 4 tables having one resident eating and the others at the table without food. Residents who required assistance with eating were served before residents who could feed themselves. All residents were served their food by 8:42 a.m. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and LPN-D stated each CNA had their own process for how and when they would get the residents up each morning. LPN-D stated breakfast used to come up earlier, around 7:30 a.m. - 7:45 a.m., which worked out better for the residents, stating the staff try to "entertain" the residents as best they can while waiting for breakfast. LPN-D stated it gets hard to keep the residents calm in the dining room, stating you can feel the energy change in the room as time goes on and it felt like "we [staff] are just waiting for something to happen." LPN-D stated bringing the residents out to the TV room while waiting for breakfast was not something they had tried before but could try to reduce the institutionalized feel of the breakfast meal. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) stated they had just hired a new dietary manager and were working on food times and mealtimes, stating mealtimes used to be earlier. The DON stated the	F 550		

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F 550	Continued From page 5	F 550		

expectation would be to keep the residents engaged while waiting for breakfast either in their room or out in the main TV area.

Clothing Labels

R108's quarterly Minimum Data Set (MDS) assessment, dated 5/14/24, indicated R108 had severe cognitive impairment and partial to moderate assistance with activities of daily living (except eating) and ambulation in the unit hallways.

During observation on 6/10/24 at 4:04 p.m., R108 was sitting in the main dining area, wearing blue slippers with her first and last name visible on the top of her slippers.

During observation on 6/11/24 at 2:41 p.m., R108 was sitting in the main dining area, wearing blue slippers with her first and last name visible on the top of her slippers.

During observation on 6/12/24 at 7:26 a.m., R108 was sitting in the main dining area, wearing blue slippers with her first and last name visible on the top of her slippers. R2 was also sitting at a table with her first and last name visible on the outside of her slippers.

During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and LPN-D stated she was aware clothing labels being visible on the outside of clothing was a dignity concern for residents, confirming the label should not be visible on R2's or R108's slippers.

During an interview on 6/13/24 at 8:27 a.m.,

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F 550	Continued From page 6 laundry aide (LA)-A stated the process for labeling clothing, including slippers and socks, was to label clothing on the inside of clothing for the safety of the residents. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) confirmed the expectation for labeling clothing was to place all labels on the inside of clothing. R49's quarterly MDS dated 5/15/24, indicated R49 had moderate cognitive impairment and was diagnosed with kidney disease, depression, and a stroke with aphasia (a disorder affecting speech). The MDS indicated R49 was able to independently wheel 50 feet, required set-up help for eating, and was dependent on staff for transfers. R49's care plan dated 4/8/24, indicated R49 enjoyed watching television, visiting the courtyard, and socializing with peers. The care plan indicated staff would assist R49 with activities as needed and encourage and invite R49 to said activities. During an interview on 6/10/24 at 2:29 p.m., family member (FM)-B stated R49 had a stroke and had resulting difficulties with speech but R49 still knew what he wanted and was able to communicate through nodding to yes or no questions. FM-B stated when he came to visit, he would often find R49 sitting in the dining room with no activities going on or a television playing. FM-B stated it bothered him R49 was left there with nothing to do as he knew R49 would not like this. FM-B stated R49 was always an	F 550		

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F 550	Continued From page 7	F 550		

independent person and didn't necessarily like other group activities but had always liked to watch television.

During an observation on 6/13/24 at 8:24 a.m., R49 was observed sitting at a dining table on the far-right side of the dining room facing the wall.

During an observation on 6/13/24 at 8:42 a.m., R49 was observed sitting at a dining table eating breakfast.

During an observation on 6/13/24 at 9:06 a.m., R49 was observed sitting at a dining table by himself eating breakfast.

During an observation and interview on 6/13/24 at 9:19 a.m., R49 was observed sitting at a dining table by himself and when asked if he was done eating, R49 nodded his head yes.

During an observation on 6/13/24 at 9:31 a.m., R49 was observed sitting at a dining table by himself.

During an observation on 6/13/24 at 9:49 a.m., R49 was observed sitting at a dining table by himself facing the wall on the right side of the dining room. Three other residents were observed sitting around a table facing and watching television on the left side of the dining room (behind R49). When R49 was asked if he would like to watch television, he nodded his head yes. When asked if anyone had offered to bring him over to the television, he shook his head no.

During an observation and interview on 6/13/24 at 9:51 a.m., housekeeper (H)-A was observed

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F 550	Continued From page 8 sweeping up food debris from the dining room floor. H-A stated she had seen R49 and other residents sitting in the dining room with no entertainment for a long period after meals and this had led to residents becoming visibly upset to the point of crying in the past. During an observation on 6/13/24 at 10:07 a.m., R49 was observed sitting at a dining table by himself facing the wall on the right side of the dining room. R49 was observed attempting to push himself away from the table but the right wheel appeared locked so the wheelchair turned to the right but appeared unable to move farther. R49 was then observed to put his head in his hand and look down towards his lap. During an observation on 06/13/24 10:23 AM, RN-E, the nurse manager for the unit, was observed to approach and quickly converse with R49 and was then observed to leave the dining room. During an observation on 6/13/24 at 10:43 a.m., activity staff (A)-B was observed to approach R49 and ask if he wanted to sit by the tv, he nodded yes, and she pushed him in his wheelchair and sat him with the other residents watching television. During an interview on 6/13/24 at 10:48 a.m., RN-E stated she did not think anyone had offered to assist R49 to the other side of the dining room to watch television with the other residents until the occurrence at 10:43 a.m. RN-E stated she would have expected floor staff to offer R49 assistance to the other side of the dining room to watch tv or take him back to his room.	F 550		

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F 550	Continued From page 9 During an interview on 6/13/24 at 1:47 p.m., the DON stated she would have expected floor staff to assess what R49's preferences were after a meal, such as returning to his room or participating in other activities. The DON stated she would not want R49 stuck sitting alone at his table with nothing to do as it could lead to feelings of sadness. Facility policy on dignity was requested and not received.	F 550		
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	F 583		7/17/24

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F 583	Continued From page 10 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 by: Based on observation and interview, the facility failed to ensure resident records which contained private, medical, and personal information were kept private and not accessible to unauthorized personnel for 1 of 1 residents (R35) reviewed for privacy. Findings include: During observation on 6/10/24 at 5:35 p.m., an unattended medication cart located at entrance of second floor dining room with laptop open to R35 medication list was observed. Dining room had 12 residents in the room eating dinner and numerous staff walking past the medication cart. During observation and interview with registered nurse (RN)-C on 6/10/24 at 5:36 p.m., RN-C walked up to the unattended medication cart and closed the laptop screen. RN-C stated, "nurses should be sure the med carts are locked and laptop should be closed due to privacy". RN-C stated the nurse responsible for the unattended medication cart was not "in the area" and would try to locate them. During interview with licensed practical nurse (LPN)-B on 6/10/24 at 5:37 p.m., LPN-B stated he was responsible for the unattended medication	F 583	F583 1.R35 was not affected by this practice. 2.All residents have the potential to be affected by this practice. 3.All licensed staff will be educated on ensuring the laptop is closed with no protected health information visible and locked when unattended. 4.Five audits will be completed weekly x4 weeks. Then 1x week for 4 weeks. Audits will be conducted by Don or designee. 5.Audits will be brought to QAPI by NHA or designee to review trends.	

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F 583	Continued From page 11 cart and, "it is a violation [to leave the resident medical record visible when walking away from the medication cart]. The laptop should be turned off due to HIPAA [Health Insurance Portability and Accountability Act]. During interview with director of nursing (DON) on 6/11/24 at 9:11 a.m., DON stated, "medication carts should always be locked when staff step away from the cart. The laptop should be turned off [when leaving the med cart]." Facility policy provided to survey team by administrator titled Department of Health Combined Federal and State Bill of Rights for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities, revised 6/18/19 states, "The resident has a right to personal privacy and confidentiality of his or her personal and medical records."	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		7/17/24

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F 584	Continued From page 12 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote a dignified home like environment for 6 or 6 residents (R61, R13, R126, R22, R63, R68). Findings include: R61's Annual Minimum Data Set (MDS) assessment, dated 5/7/24, indicate admission to facility on 11/9/23 and had severe cognitive impairment. In addition, R61 with no impairment of upper and lower extremities, utilized a walker and wheelchair for mobility, and required	F 584	F584 1.R61 was not affected by this practice. R61 had refused to wear catheter bag cover. This was communicated on this care plan. On 6/11 the facility replaced with a fig leaf catheter bag. Resident has allowed this. Residents R22, R126, R63 and R68 had previously never informed facility of concerns regarding catheter bag and are not affected. 2.Residents R22, R126, R63 and R68 will	

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F 584	Continued From page 13 substantial assistance with toileting and personal hygiene, and dressing. Also, R61 with diagnoses of benign prostatic hyperplasia (enlarge prostate gland making it difficult to empty bladder), polyneuropathy (numbness in extremities), urinary retention, transient ischemic attacks (cerebral stroke affecting brain function), adjustment disorder, and had an indwelling catheter (to drain urine from bladder into a bag). R61's physician orders (PO) dated 11/3/23 included, "Foley Catheter: Please apply leg bag during the day & overnight bag during the evening/night". R61's care plan (CP) dated 6/7/23 indicate, "Resident has history of refusing foley catheter leg bag during the day. Has been observed removing the catheter bag cover after it was applied by staff". The CP did not provide interventions to re-approach or offer alternatives to covering the bag when out of his room. During observation on 6/11/24 at 12:45 p.m., R61 sitting on seat of wheeled walker in the main lounge at a dining room table alone. R61's large uncovered catheter bag was hanging on the brake handle of his wheeled walker above the height of his bladder and visible to several staff and residents in the room. The uncovered catheter bag had yellow urine in the tubing and bag. During interview with registered nurse (RN)-A on 6/11/24 at 12:51 p.m., RN-A stated, "not acceptable to have it [catheter bag] above the bladder. It must be below bladder and covered in a bag for dignity and privacy." RN-A stated, "[it is] not ok for catheter to be exposed."	F 584	be interviewed to ensure they feel their environment is comfortable and homelike. Other residents with catheter bags will be reviewed to ensure they have covers. Education will be completed with nursing staff regarding having a comfortable, homelike environment and catheter bags being covered. Resident rights will be reviewed with all new admissions. 3.Five audits will be completed x4 weeks. Then once x4 weeks. Audits will be conducted by DON or designee. 4.Audits will be brought to QAPI by NHA or designee for review to determine any trends.	

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F 584	Continued From page 14 During interview with nursing assistant (NA)-A on 6/11/24 at 12:55 p.m., NA-A stated, "the urine bag should be covered in a bag for dignity and its got to be below the waist. Urine should flow in one direction, down. No one wants to see the urine in the bag." During interview with RN-C on 6/11/24, at 2:48 p.m., RN-C stated, "catheter bags should always be covered for dignity. For [R61] it is care planned that we have tried everything to get him to agree to cover it up. He refuses. He gets nasty and we try again. I agree it is not ideal for the other residents to have to see his urine. Don't know what else we can do." During observation on 6/12/24 at 7:29 a.m., R61 sitting on seat of wheeled walker in the second floor dining room. Five other residents (R13, R22, R126, R63, and R68) were seated at tables awaiting breakfast. R61 seated across from R13 at the dining room table. R61's urine drainage bag was uncovered and visible to everyone in the dining room including the nursing station adjacent to the dining room. During interview with R13 on 6/12/24 at the same time as observation, R13 stated, "I can't see it from where I am sitting now but I don't really like that thing uncovered. Who wants to see another person's pee[urine]? I would rather not, especially when I am eating or out in the hall or at activities." During interview with R22, R126, R63, and R68 at 7:32 a.m., R22 stated, "Its gross to see that pee in that bag. He don't care but I do. I don't want to see it while I am eating." R126 stated, "Yeah, he [R61] don't care about the rest of us having to	F 584		

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F 584	Continued From page 15 see that icky bag" and "[I] wish [R61] would go eat in his room so I don't have to see it. I just sit where I am not facing it." R63 stated, "[R61] always walks around with that bag uncovered." And "[I] wish he didn't because I do not like to eat with that bag visible to me. This is my home too, so I don't think I have to put up with it just because he doesn't want to cover it." R68 stated, "why do we have to see that thing? [R61] don't look at it like we have to. I am about to eat here and I look away. Why is it ok for him to have that thing uncovered so all of us have to look at it? Its not fair". During interview with NA-F on 6/12/24 at 7:45 a.m., NA-F stated, "[catheter bags] should be covered at all times because of dignity." And "It bothers the other residents but he don't care". During interview with director of nursing (DON) on 6/13/24 at 8:11 a.m., DON stated expectation of all catheter drainage bags to be always covered with privacy bag due to, "dignity". DON stated R61's care plan failed to provide guidance and suggestions for alternatives to his refusal of having a dignity bag to cover his catheter. DON stated there was discussion with the interdisciplinary team regarding his refusals but there was nothing in the medical record to address it. DON stated, R61's CP interventions failed to address re-approaching him or offering alternatives to covering the bag when out of his room. Facility policy on dignity was requested and not received.	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		7/17/24

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F 600	Continued From page 16 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents on a secure memory unit were free from harm for 2 of 2 residents (R82 and R17) reviewed for resident-to-resident abuse. This resulted in actual harm when R17 was struck in the face by R82 causing a subconjunctival hemorrhage of the left eye (broken blood vessels in the eye) requiring emergency medical attention. Findings include: According to the state agency (SA) Incident Report, dated 6/9/24, identified a facility's reported allegation of physical abuse involving R17 and R82. The report outlined R17 reported he was struck by R82 in the eye with the incident occurring in R17's room. R17 had a laceration on his left eye and transported to the hospital for evaluation.	F 600	F600 1.R82 was put on 1:1 and currently remains on 1:1 due to increased agitation. Pharmacy will review R82's medications regimen to ensure appropriateness. R17 has been assessed. There have been no further alleged allegations between R82 and R17. Care plans have both been updated. No further recommendations from ACP or MD provider. 2.Residents on the dementia unit have the potential to be affected. 3. Abuse education will be completed with all staff. Staff will be educated on how to handle residents with aggressive behaviors. Specially, around how to de-escalate a situation and prevention of altercations. What documentation is	

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F 600	Continued From page 17 R82 R82's quarterly Minimum Data Set (MDS) assessment, dated 5/15/24, identified R82 had dementia, post-traumatic stress disorder (a psychiatric disorder that may occur after experiencing or witnessing a traumatic event), restlessness, agitation, and severe impaired cognition. Furthermore, R82 demonstrated able to walk in room and unit independently, no hallucinations or delusions. No physical or verbal behaviors . R82 noted to wander daily and reject cares one to three days in the last 7 day look-back period for MDS. R82's care plan, identified R82 moved into facility on 8/5/21 and resides on locked memory care unit. R82's care plan included, -R82 at risk for alterations in behavior related to trauma, including PTSD(post-traumatic stress disorder) from time spent in Vietnam war with a goal resident will develop coping skills to address stated trauma . Interventions included: redirect resident to a different activity to help self sooth and when resident is getting agitated and engages in screaming, redirecting him from other residents is of value for safety. - R82 had a history of "aggressive behavior including verbal and/or physical altercations with other residents," The goal was to prevent reoccurrence and keep other resident safe . -R82's has alteration in socialization related to difficulty engaging due to diagnosis of dementia and related cognitive deficits. Resident appears to enjoy visiting with staff and other resident around him. Resident would benefit from	F 600	needed and interventions to ensure safety of residents. Education with nurse leadership and social services on updating care plan with interventions for altercations. 4.Five audits will be completed weekly on the dementia unit to ensure residents with aggressive behavior have appropriate documentation and interventions in place. 5.Audits will be brought to QAPI by NHA or designee to review trends.	

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F 600	Continued From page 18 socializing with others during group activities. Resident also enjoys music groups and independently listening to music in his room. -R82 has alteration in behavior related to diagnosis of dementia. Resident often wanders and enters other residents' rooms , The goal related "resident will respond to intervention by staff to calm and redirect . R82 does have periods of increased confusion and agitation .... will typically increase in the afternoon. At times, resident is difficulty to redirect ...history of wandering... has history of physical altercations with other residents. Goal of resident will respond to interventions by staff to calm and redirect with a revision date of 4/19/24. Interventions included: Staff reported more wandering and anxiety in the night. Implement an exercise program where staff walk with him in the hallway for 5-10 minutes in the evenings to help release excess energy and anxiety with initiation date of 5/6/24. -R82 Care plan included an alteration in psychosocial wellbeing related to diagnosis of Dementia. Resident is pleasant at baseline, preferring to be around others for most of the day, liking to converse with others, though often conversation is hard to follow. Resident has periods of increased agitation or restless, will start walking around the unit quickly and asking others to help him get to his car. R82's treatment administration record (TAR) for 5/1/24 and 6/13/24 had the following order for staff to monitor and document altercations if the following behaviors were identified: picking at skin, restlessness, agitation, hitting, increase in complains, biting, kicking, spitting, cussing, racial	F 600		

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F 600	Continued From page 19 slurs, elopement, staling, delusions, hallucinations, psychosis, aggression, refusing care. The records indicate staff checked the box R82 had behaviors every shift for the month of May and June except one shift. R82 had a history of behaviors prior to most recent incident involving R17 as indicated in R82 progress notes: -2/1/24 at 2:19 p.m.: exiting seeking ...another resident keeps talking to resident ...causing resident to become increasingly agitated. -3/7/24 at 1:21 p.m.: emotional and exit seeking -3/13/24 at 11:52 a.m.: agitated, pacing and shouting at others -3/13/24 at 9:42 p.m.: agitated -4/7/24 at 5:19 p.m.: was exit seeking and agitated. -5/3/24 at 6:31 a.m.: aggressive with staff with cares, resident "not able to calm down, he started chasing other res [resident] cursing and yelling ... difficult to calm down." -5/3/24 at 7:50 a.m.: physical altercation with another resident. R82 was transferred to the hospital for further evaluation as was bleeding from right eye. -5/4/24 at 7:23 a.m.: exhibited escalating behaviors including grabbing a fire extinguisher from wall, attempting to hit staff with it, and was unable to be redirected. All other resident doors needed to be shut for safety. R82 attempted to fight another resident.	F 600		

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F 600	Continued From page 20 -5/4/24 at 9:59 p.m.: aggressive during cares and attempted to "elbow" a nursing assistant. -5/9/24 at 11:52 a.m.: exit seeking. -5/18/24 at 4:03 p.m.: exit seeking. -6/1/24 at 9:44 p.m.: pacing the hallways, going back and forth between all the doors looking for how to get out. -6/4/24 at 7:17 a.m.: refused cares despite multiple attempts. -6/7/24 at 3:29 p.m.: attempted to strike a nursing assistant with the shower hose during care. -6/9/24 at 7:37 p.m., reported by R17 that R82 entered R17's room and struck him in the eye, R82 unable to explain. Although R82's TAR indicated behaviors charted daily by staff, the progress notes lacked daily documentation of what altercations R82 were exhibiting and what interventions were implemented. R82's nursing assistant care sheet, included R82 was independent with ambulation and transfers. History of res [resident] to res [resident] and whom altercations occurred with. R17 R17's care plan identified: -R17 is a vulnerable adult while residing in a skilled nursing facility and is at risk for decreased cognitive and physical ability related to diagnosis included dementia . The goal related "resident will	F 600		

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F 600	Continued From page 21 remain free from abuse and/or neglect . -R17 is at risk for alteration in psychosocial well-being related diagnosis of dementia while residing on a secure memory care unit. At baseline. Resident is pleasant to others, though often keeps to himself. Resident does like to watch TV in the common area with others. He likes to watch the other resident . Accused another resident of hitting him in the chin, no injury noted, and this was unwitnessed. Resident gets upset when other residents wander into his room . Stop sign on the doorway of his room to help prevent other resident form entering his room with a date initiated of 1/22/24 with a revision added after altercation on 6/12/24, [R17] often takes the stop sign off his door and he will put it in his drawers or closet. During an observation and interview on 6/10/24 at 2:03 p.m., R17's left eye was black and blue and the white of his eye was bright red. R17 indicated he was punched by another resident which caused his black and blue eye. R17 denied pain at this time. There was no "stop sign" observed to be on R17's door when entering. During follow up observation on 6/11/24 at 1:22 p.m., there was no stop sign observed to be hanging on R17's door. During breakfast on 6/12/24 at 8:17 a.m., R17 stated, he was hit in the eye by another resident. On 6/12/24 at 8:31 a.m., during an observation, it was noted there was no stop sign on R17's door. R17's quarterly MDS assessment, dated 5/7/24, identified R17 had dementia, schizophrenia,	F 600		

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F 600	Continued From page 22	F 600		

slurred speech, and severe cognitive impairment. MDS indicated R17 used wheelchair for mobility and dependent on staff for transferring to and from wheelchair. R17 noted to have verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others) and other behavioral symptoms not directed towards others both of which occurred one to three days.

R17's nursing assistant care sheet, identified R17 was HOH [hard of hearing] has a pocket talker to aide with HOH, R17 was "Assist of 1 with transfers. He often self-transfers. Stop sign on his door to prevent others from entering.

R17's progress notes included the following:

2/1/24 at 2:22 p.m. R82 had been wandering around the dining room and hallways exiting seeking and R17 continues to talk to R82 stating thinks like "I'll knock you out, and I'll through you out the window". R17 has some speech that is hard to understand and R82 is becoming agitated with R17. Writer asked R17 not to talk to R82 and give him space. R17 continues to move seats in the dining room and go near R82 and make statements causing more and more agitation to R82. Staff will redirect as necessary.

6/9/24 at 7:33 p.m., writer went to resident room at around 8:20 a.m., to check with him and remind him to come out for breakfast. Noted resident left eye reddened. Per resident, someone came to his room and punched him to his eye. Resident was asked to come out with writer and identify the person who had punched him. He came out and went straight to dining area where he pointed at a resident R82. Resident has

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F 600	Continued From page 23	F 600		

impaired speech, he was heard mumbling and pointed at R82 "he punched me, he did it." ....sent to hospital for further evaluation.

6/9/24 at 10:23 p.m., patient returned from emergency department, no new orders, or treatments.

R17's emergency department note, dated 6/9/24, indicated R17 was seen following an assault. R17 reported some pain in left eye and "a little more difficult to see out of the left eye but is still able to see." CT scans indicated no evidence of acute hemorrhage, or skull fracture and no orbital, facial bone, or mandibular fracture. R17 discharge diagnosis subconjunctival hemorrhage of left eye.

R17's record lacked interventions to prevent additional verbal or physical altercations.

During an interview on 6/12/24 at 10:32 a.m., licensed practical nurse (LPN)-E verified working with R82 and R17 for over a year. LPN-E indicated received report R82 hit R17 . LPN-E reported no other incidents (verbal or physical altercations) between R17 and R82. LPN-E stated R17 should have a stop sign on his door but "he takes it off all the time". LPN-E indicated the stop sign was to stop other residents from entering his room.

On 6/12/24 at 10:39 a.m., nursing assistant (NA)-M verified working with R82 and R17 for over a year. NA-M indicated they worked the morning of 6/9/24. NA-M stated they were in the dining room when R82 walked up to them and hit NA-M in the arm stating, "do you need another?" NA-M stated they encouraged R82 to sit in the dining room, and it was shortly after R17 reported

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F 600	Continued From page 24 R82 hit him in the face. NA-M stated they do not know of any other incidents (verbal or physical altercations) between the two residents but adds "we have been trying to follow him around since this happened." NA-M verified R17 should have a stop sign on his door and does not have it on there. NA-M was able to find the stop sign which was found in R17's drawer. On 6/12/24 at 10:54 a.m., NA-B verified they are familiar with R17 and R82 and have worked with them for over a year. NA-B stated they knew about the physical altercation between R17 and R82. NA-B stated R82 has been more aggressive recently and difficult to get things done. NA-B stated, "we just re-approach a lot and offer a lot of reassurance.". NA-B stated there have been no other incidents (verbal or physical altercations) between R17 and R82. On 06/12/24 at 2:22 p.m., LPN-D verified they update the care plans. LPN-D reviewed the chart and verified the verbal altercation with R17 and R82 on 2/1/24. LPN-D verified the care plan had not been updated. LPN-D stated R17 was having an increase in behaviors due to having a gradual dose reduction on a medication, a urinary tract infection and then kidney stones. LPN-D verified this was not on his care plan. LPN-D indicated R17 and R82 are seated at separate tables in the dining room, R17 has a stop sign on his door, "put in extra behavioral monitoring," the unit is small so "we can watch people closely," and "make sure staff are aware of the situation so we can continue to watch and see problems." LPN-D further indicated "it's not like it's a daily occurrence" referring to R17 and R82. LPN-D verified R17 or R82's care plans had not been updated following the 2/1/24 verbal altercation.	F 600		

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F 600	Continued From page 25 On 6/13/24 at 12:04 p.m., administrative administrator (AA) and administrator verified they were familiar with R17 and R82 and recent incidents. AA indicated on 2/1/24 there was an argument between R17 and R82. The interventions to follow were staff asked R17 not to talk to R82, R82 was seen by Associated Clinic of Psychology (ACP) on 2/5/24 and a (Patient Health Questionnaire-9) PH-Q9 completed on 2/6/24 with "no disturbances." AA and administrator agreed there were no similar incidents. AA stated she was on-call on 6/9/24 and received a call from the supervisor regarding the physical altercation. AA verified she filed the state agency report. AA explained what had been done immediately following the physical altercation. AA verified R17's care plan had been updated on 6/12/24 following the incident. When asked what had been added since the verbal altercation to R17's care plan to prevent another altercation, AA stated "I don't know, I need to look thoroughly". AA verified R82's care plan had been updated on 6/12/24 regarding a new medication for behaviors. AA stated she needed to look at R82's care plan more to verify if it had been updated to reflect 2/1/24 incident. On 6/12/24 at 12:30 p.m., administrator stated, "I did not have a chance to look into IDT [interdisciplinary team] notes yet." Administrator indicated "I think there was education to staff on the floor following each of the incidence." An in-service training record for all staff, dated 2/15/24, indicated the abuse policy, review that facility must report abuse to the state within 2 hours, and when to notify nursing home administrator and notification of director of	F 600		

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F 600	Continued From page 26 nursing guideline. Two items are highlighted on each: serious injuries such as a fracture and resident to resident altercations. The abuse prohibition / vulnerable adult policy was attached. No further documentation was provided on any education provided to staff regarding these incidents. Furthermore, no documentation was provided on how to ensure other resident safety with a resident with known and multiple aggressive behaviors. Documents provided by facility after survey exit, on 6/17/24, included R17 and R82's care plan with highlighted areas, ACP notes for R17 and R82, timeline of events following 2/1/24 and 6/9/24 incidents and R82 medication changes were reviewed. The additional documentation lacked evidence on how the facility ensured through specific interventions, staff education, or care planned interventions to ensure the safety of R17 from physical abuse from R82 who had known history and increasing aggressive behaviors. A facility policy titled "Abuse Prohibition/Vulnerable Adult Policy", review date 3/24, was provided. The document indicated the purpose is "to protect resident against abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends or other individuals, or self-abuse." Furthermore, under the prevention section, "The Interdisciplinary Care Plan Team reviews residents requiring behavioral interventions at least quarterly and/or during Target Behavior meeting to develop individual behavior plans."	F 600		

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure timeliness of person-centered care conferences were conducted to ensure resident goals and preferences were discussed for 1 of 1 residents (R93) reviewed for care conferences. Findings include:	F 657	F657 1.R93 had a care conference on 6/25/2024. 2. All residents have the potential to be affected. Residents who were admitted in the last 30 days will be reviewed to ensure the initial care conference was	7/17/24

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F 657	Continued From page 28 R93's quarterly Minimum Data Set (MDS) assessment, dated 3/28/24 identified admission to facility on 4/6/22, was severely cognitively impaired, with diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's electronic medical record (EMR) indicates MDS assessments were completed on 4/12/22, 7/9/22, 10/5/22, 1/3/23, 3/30/23, 6/9/23, 9/27/23, 12/28/23, and 3/28/24. R93's EMR indicated care conferences were conducted on 1/4/23, 3/29/23, 4/5/23, 10/5/23 and 2/19/24. R93's medical record failed to show care conference were conducted on 4/12/22, 7/22/22, 10/5/22, 6/9/23, 12/28/23. During interview with director of nursing (DON) on 6/13/24 at 8:27 a.m., DON stated care conferences are expected, "to be done quarterly and with significant change status". During interview with social services director (SS)-D on 6 13/24 at 9:57 a.m., SS-D stated she had been in role since 2022. SS-D stated, care conferences "should be done quarterly and 21 days after admission". SS-D stated care conference timing are "expected" to be done with each MDS assessment. SS-D looked in R93's EMR and stated his care conferences were, "not done for a year". SS-D stated there were missing care conferences for R93. Facility policy on care conference timing was	F 657	conducted timely. Residents who were due for quarterly care conference will be reviewed to ensure care conference was scheduled/completed per requirement. 3. Care conference education will be completed with social services staff. Social Services staff will be educated on timeliness of person-centered care conferences to ensure resident goals and preferences were discussed. 4.Five audits will be completed x4 weeks to ensure residents have a care conference scheduled timely. Then once weekly x4 weeks. 5.Audits will be completed by the director of social services and or desigee. Audits will be brought to QAPI for review by SS or designee.	

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F 657	Continued From page 29 requested and not received.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech,	F 676		7/17/24

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F 676	Continued From page 30 (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure routine personal hygiene assistance was provided to 2 of 2 residents (R28 and R56) reviewed for ADLs. In addition, facility failed to implement a communication system to ensure resident needs were met for 1 of 1 resident (R93) whose primary language was not English. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 5/16/24 identified admission to facility on 1/5/12 and intact cognition. During observation on 6/10/24 at 2:13 p.m., R28 laying in bed, dressed and had black matter under her fingernails. During observation and interview with R28 on 6/11/24 at 2:27 p.m., R28 laying in bed, dressed and had black matter under her fingernails. R28 stated, "No, no one asks me if they can cleanout my nails. They can be gross if not soaked and taken care of. The aide [nursing assistant] should be asking me at least." During interview with registered nurse (RN)-D on 6/11/24 at 2:27 p.m., RN-D stated she had worked full time at the facility for "five years" and normally worked on the unit with R28. RN-D stated, "nurses are responsible for making sure the nails are cleaned and washed up for the day." RN-D looked at R28's nails and stated, "they should be cleaned and trimmed."	F 676	F676 1.R 28s fingernails were cleaned and R56s facial hair was trimmed. Residents care plan and care guide for residents who do not primary speak English were updated to reflect how to communicate with them. Staff are able to communicate with R93 through an interpreter service line and communication picture book. Care plan has been updated to include language communication board. 2. Residents will be reviewed to ensure nails are clean and groomed per preference. Those who are non-English speaking will have care plans reviewed to ensure appropriate means of communication. 3.All licensed staff will be educated on ensuring residents' fingernails are cleaned/trimmed weekly on shower days and as needed. Educate on ensuring resident preferences are followed in regard to facial hair and ensuring it's being offered on shower day and as requested, or staff identify. All staff will be educated on how to communicate with a resident whose primary language is not English. Communication boards will be provided for staff to use with residents whose primary language is not English. These boards will be available on nurses station and with resident. An interpreter line is available. This number is posted at the	

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F 676	Continued From page 31 During interview with RN-C on 6/11/24 at 2:48 p.m., stated she was the nurse manager of the unit R28 resides on. RN-C stated, nursing assistants should take care of nail care right away. During interview with RN-C on 6/12/24 at 8:10 a.m., RN-C said she looked at R28's nails yesterday,they are taken care of now and verified R28 had black stuff under them which needed to be cleaned. During interview with director of nursing (DON) on 6/13/24 at 8:28 a.m., DON stated nail care is to be done, "weekly" and as needed. R56's quarterly MDS assessment, dated 4/4/24, indicated R56 had intact cognition. MDS indicated R56 required partial assistance for shaving. MDS indicated no behaviors or rejection of care. R56's care plan, identified R56 needed "assist with facial shaving- weekly on bath day as needed." R56's nursing assistant care sheet identified R56 was "assist of 1 for all ADLs-make sure she is completing hygiene daily. Shave facial hair as needed on shower day.". On 6/10/24 at 1:21 p.m., R56 was observed standing in her room and had a facial beard, approximately half inch long. R56 stated, "I would feel better if it was gone .... I would like to try something, maybe an electric razor." R56 indicated "they gave me a razor once, but it left it rough," and further expressed that she did not like the facial hair, and would like it gone.	F 676	nurses station and in PCC under special instructions. 4.Audits will be completed of resident fingernails at 5 audits per week x4 weeks. Audits will also be completed of resident facial hair at 5 audits per week x4 weeks. Audits will be completed for residents who do not primary speak English at 5 audits per week x4 weeks. Then each audit will be completed once weekly x4 weeks. 5. Audits will be brought to QAPI by DON or designee.	

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F 676	Continued From page 32 On 6/11/24 at 1:15 p.m., R56 was observed in her room. R56 stated she had just taken a shower and stated, "they helped me shave". R56 further expressed, "I feel much better". R56 stated "they don't always do that but did today ... ...used a razor that just rolled over and it worked pretty good .... I feel a lot better." R56 stated it's "been a while... I don't remember the last time they asked me about shaving." On 6/13/24 at 9:37 a.m., licensed practical nurse (LPN)-E stated R56 was assist of 1 with ADLs, needs set up, and needs staff assistance to shave facial hair once a week on shower days as needed. LPN-E verified this on the nursing assistance sheet. On 6/13/24 at 9:42 a.m., nursing assistant (NA)-J verified they are familiar with R56. NA-J stated R56 needs "set up" for most ADL's, further clarifying staff set up her clothing and she can put them on herself. NA-J stated R56 needs set up and stand by assist for showers and R56's "facial hair is done by staff on shower days." NA-J stated it is important to keep R56 facial hair shaved "for dignity purposes." On 6/13/24 at 11:15 a.m., director of nursing stated getting rid of facial hair for women is a dignity issue, want to make sure that residents are presentable and feel good. A facility policy titled "Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 5/9/24, was provided. The document indicated it will "create and sustain an environment that humanizes and individualizes each resident's quality of life."	F 676		

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R93

R93's quarterly Minimum Data Set (MDS) assessment dated 3/28/24 indicates admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). In addition, R93's "preferred language" was documented as "OTHER".

R93's Care Area Assessment (CAAs) dated 6/29/23, identified Communication as a concern.

R93's care plan (CP) dated 4/8/22 reads Alteration in communication r/t primary language Vietnamese. Resident does not understand English, with the interventions to;
-Staff will use interpreter phone line schedule an interpreter to communicate with resident,
-Speak clearly and distinctly to resident or use resident preferred communication method,
-Alternate communication method, use of interpreter phone line."

R93's care sheet updated 6/6/24, direct staff to "Use interpreter line, resident speaks Vietnamese".

During interview with nursing assistant (NA)-B on 6/10/24 at 1:36 p.m., NA-B stated he was full time employee and worked over fifteen years at facility and is familiar with R93. NA-B stated, "I don't use anything to communicate with [R93]. There is nothing on the walls here to help us figure out

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what [R93] wants. I will usually just look at his face and speak slowly. I don't really know if [R93] understands me. [R93] just goes along with it. Nothing in the care sheet [that I know of] about communicating with [R93] using a language board or language line."

During observation on 6/10/24 at 5:40 p.m., R93 sleeping in bed. Interpreter line phone number with password printed on paper is attached to R93's closet door.

During interview with licensed practical nurse (LPN)-A on 6/11/24 at 8:38 a.m., LPN-A stated she was "very familiar with [R93]." LPN-A stated, "we don't do anything to help him communicate. There are no signs on the walls or near him to help us talk to him. We just ask yes or no questions. That is all." And, "His primary language is not English."

During interview with NA-F on 6/12/24 at 7:45 a.m., NA-F stated she was "familiar with [resident care on R93's wing]" NA-F stated, "I go off facial expressions. I go by care plan and grimacing. He is not verbal" and, "[I have] never seen any staff use the interpreter line for R93".

During interview with director of therapeutic services (DT) on 6/12/24 at 10:51 a.m., DT stated, "I would recommend the interpreter [for staff to communicate with R93]. It is the best shot in the dark to communicate with him. R93 is non verbal." Also, "R93 was given a communication board with pictures along with Vietnamese and English words. [It] should be there [and visible] for staff to bridge the gap."

During interview with family member (FM)-A on

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F 676	Continued From page 35 6/12/24 at 11:15 a.m., FM-A stated, "there is a phone number staff can use to get an interpreter for R93. I expect them to use the language line if there is a question R93 can answer." During interview with RN-D on 6/12/24 at 11:20 a.m., RN-D looked at R93 electronic medical record (EMR) including care plan and stated, "language board should be in the care plan. I don't see anything in R93 chart to tell staff [about using] a language board." During interview with RN-C on 6/12/24 at 11:32 a.m., RN-C looked at R93's EMR and stated, "[R93] has a communication sheet that he can point to for us" and, "No it is not in the care plan for staff to use the communication sheets [language board] to communicate with [R93]." During interview with RN-H on 6/13/24 at 9:15 a.m., RN-H stated, "If someone is not English speaking, we are supposed to use interpreter line to communicate such things as, 'where is your pain? And questions not requiring a yes or not answer." Also, RN-H stated, "we all need to look in the care plan to see if we are to use an interpreter." Facility policy titled Interpreter Policy updated 02/2024 state, "language access services must be provided to patients with limited English proficiency (LEP)".	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan	F 679		7/17/24

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F 679	Continued From page 36 and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's preferred activities for individual entertainment were available for 1 or 1 residents (R93) reviewed for activities. Additionally, facility failed to comprehensively assess for, and provide, individualized activities for 1 of 1 transitional care unit (TCU) resident (R106). Findings include: R93's quarterly Minimum Data Set (MDS) assessment dated 3/28/24 indicates admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). In addition, R93's "preferred language" was documented as "OTHER". R93's Therapy Recreation Evaluation and Social History evaluation on 4/6/22 state R93 nationality of Vietnamese, and enjoyed "fishing, listening to music and watching movies." R93's care plan (CP) dated 4/7/22 with a focus of, "1) Alteration in socialization, potential for activity	F 679	F679 1.R93 will have a new therapy recreation evaluation and social history evaluation completed and resident will be provided a TV. R106 will have an initial therapeutic recreational evaluation and social history form completed. 2.Residents who are dependent will have their therapeutic recreation preferences reviewed to ensure items are in place. Admissions for the last two weeks will be reviewed to ensure therapeutic recreation evaluation has been completed and preferences being followed. 3.All therapeutic recreation staff will be educated on completing the therapeutic recreation evaluation and social history form. 4. Audits will be completed of all new admissions to ensure the therapeutic recreational evaluation and social history form is completed and preferences are followed. Five audits per week x4 weeks for all other residents will be completed. Then audits will be completed once	

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F 679	Continued From page 37 deficit r/t Parkinson's and Hemiplegia with mobility deficit, Communication deficit". CP Intervention dated 4/18/22 state, "Provide 1:1 activities offered as resident is willing to accept them." A CP intervention dated, 10/3/22 direct staff to, "Offer one to one visits to include: reminiscing, discussion of family, life history, current events, historical facts, and other interests." R93's quarterly Care Conference Form, dated 2/19/24, state, "Resident participates in independent activities like looking out the window, family visits, 1:1 staff visits". R93's May and June 2024 Therapeutic Recreation record indicate R93 not provided or offered activities for May 10, 11, 12, 18, 19, 24, 25, 26, 30th and June 1, 2, 9, and 11th. During interview with family member (FM)-A and primary emergency contact on 6/10/24 at 3:36 p.m., FM-A stated, "I would like them [facility] to move him [R93] next to a window." And "When [R93] first got there [admitted to facility] he was next to window but roommate wanted it too, so they [facility] moved him [away from window]. [R93] is very cooped up. Activities has not worked with him. [R93] used to have TV and now he doesn't". FM-A stated watching TV and window watching was an enjoyable activity for R93 before admission to facility. During interview with licensed practical nurse (LPN)-A on 6/11/24 at 8:38 a.m., LPN-A stated she was "very familiar with [R93]". LPN-A was unaware of R93's preference to watch TV and sit by a window.	F 679	weekly x4 weeks. 5.The results will then be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Audits will be conducted by NHA or designee.	

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F 679	Continued From page 38 During interview with nursing assistant (NA)-F on 6/12/24 at 7:45 a.m., NA-F stated, "activities will come in the room but [I] don't know what he does." NA-F was unaware of R93's preference to watch TV and sit by a window. During interview with director of nursing (DON) on 6/13/24 at 8:32 a.m., DON stated, "activities department will set up and arrange [R93] activities". During interview with therapeutic director (TR) on 6/13/24 at 10:44 a.m., TR stated expectation of therapeutic recreation staff to communicate with TR about what activities were provided and which residents attended the activities being offered. Then, TR would document in the Therapy Recreation form for each resident in their EMR. TR stated he was familiar with R93 and looked in the R93's EMR. TR stated R93 did not have "visits on the weekends" and that R93 did not have a TV or radio in his room. R106's significant change Minimum Data Set (MDS) assessment, dated 5/22/24, indicated R106 had severe cognitive impairment, was dependent on staff for activities of daily living, and was admitted to the facility on 4/11/24. R106's Associated Clinic of Psychology (ACP) note, dated 4/15/24, indicated treatment recommendations including, R106 was "reporting feeling bored and lonely. He may benefit from multiple strategies such as leaving the TV on his favorite channel, having music playing, one-to-one type activities, visits from family and other similar strategies may mitigate distress and	F 679		

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improve quality of life. He may also like colorful blankets or stimulus that could be made available in his room."

R106 ACP note, dated 5/13/24, indicated R106 stated "he would like to participate more in things like music, TV shows, pet therapy and being read to. He is a good candidate for one-to-one type activities to be engaged in something like reading him. He continues to say he is depressed and anxious and will need strategies such as listening to music on headsets to help shift his thinking and mood."

R106's electronic medical record (EMR) lacked an initial Therapeutic Recreational Evaluation and Social History form.

R106's Admission Interdisciplinary Team (IDT) Note, dated 4/16/24, indicated R106 "stated interest in structured and non-structured programming" and was "able to decide participation level in structured and non-structured programs."

R106's Quarterly IDT Note, dated 5/30/24, indicated R106 "stated interest in structured and non-structured programming" and preferred "independent leisure of choice."

R106's Tasks documentation for activity participation for the month of June, printed 7/13/24, indicated different choices of activities for participation to document on such as TV room in group, wheelchair rides, 1:1 visits, group movies, group activities, family or friend visit, community outings, pet visits, socializing with others, sensory stimulation, group music, massage, etc., with an option for Active, Passive,

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F 679	Continued From page 40 Observation, or Independent participation. R106 had activity 27 (looking out the window/music/time spent in room) documented at 13:59 on the 4th, 5th, 6th, 7th, 8th, 10th, and 12th with participation listed as "P" for passive for his activity participation. During observation on 6/10/24 at 3:22 p.m., R106 was heard yelling out from his room, calling for staff, asking if he was going to get medications. R106 was laying in his bed in a hospital gown, with the door to his room half closed. No music was heard in the room and the TV was not on. During observation on 6/11/24 at 2:34 p.m. and 6/12/24 at 11:40 a.m., R106 was up in his wheelchair in his room, alone and without staff interaction, watching TV. During an interview on 6/13/24 at 11:02 a.m., the Therapeutic Recreational Director (TR) stated all residents, both transitional care and long-term residents, would be assessed at admission for social history and activities of interest using the Therapeutic Recreational Evaluation and Social History form. This form was used to create an individualized care plan and so staff was aware of what activities to invite residents to and what their interests were. The TR confirmed R106 did not have an initial assessment completed. During an interview on 6/13/24 at 12:20 p.m., nursing assistant (NA)-N stated R106 would voice feeling bored, stating he wanted to go home and "get out of here." NA-N stated R106 liked "fast cars and motorcycles" and had been asking for a radio lately but did not have one. During an interview on 6/13/24 at 12:23 p.m., an	F 679		

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F 679	Continued From page 41 unnamed recreational therapy aide confirmed they did have a radio for residents to use. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) stated the expectation was for all residents, including TCU residents, to be comprehensively assessed by the therapeutic recreation department upon admission. Facility policy on activities was requested and not received.	F 679		
F 688 SS=D	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 record review, the failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 residents (R93)	F 688	F688 1.R93 & R108 restorative program will be reviewed by therapy for appropriateness.	7/17/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 42 reviewed for limited range of motion. Further, the facility failed to maintain a resident's walking program to prevent any loss of independence, strength or range of motion for 1 of 1 resident (R108) reviewed. Findings include: R93's quarterly Minimum Data Set (MDS) assessment dated 3/28/24 included severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's physician orders (PO) dated 2/1/23 indicates, "Tx [treatment] to R[right] hand to protect from skin breakdown: Wash hand with warm soapy water, ensure skin is dried completely, weave gauze between fingers, place ABD (abdominal pads or ABD dressings for large or draining wounds) to palm of hand and wrap with kerlix. Change QOD [every other day]. Update manager and MD/NP [medical doctor/nurse practitioner] if open areas appear. Every evening shift every other day". R93's care plan (CP) goal dated 4/8/22 included, history of open area to palm of hand, Self care deficit related to impaired mobility, and contractures of URE (upper right extremity) and associated interventions of Follow OT [occupational therapy] instructions and R93 required extensive assist of 1 with personal hygiene and dressing. During observation on 6/10/24 at 1:36 p.m., R93 sitting in wheelchair in room with right hand	F 688	R93 will continue with PROM and palm guard. R108 will continue the walking program to meals. Nursing follows the recommendation. The care plan and care sheet were updated. 2. Like residents with splints and restorative care will be reviewed to ensure they are still appropriate and listed on care guides for staff. 3.All nursing staff will be educated about the importance of restorative care to prevent the loss of ROM and contractures. Residents with restorative care will be reviewed, care plan and care sheet will be updated. 4. Residents with restorative care will be potentially affected. Audits will be completed of resident with restorative care at 5 audits per week x4 weeks. Then each audit will be completed one weekly x4 weeks. 5. The results of the audits will be brought to facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits by DON or designee.	

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F 688	Continued From page 43 contracted and pulled into the torso with left hand supporting the right hand. Right hand had rolled up washcloth in it. During observation on 6/10/24 at 5:40 p.m., R93 in bed with rolled up washcloth in his hand. R93's clothes closet, which was across from R93's bed had printed PROM exercises taped to the closet door. PROM exercise instructions, dated 4/15/22 showed diagrams and explanations included, "Ankle Rotation, Knee and Hip Flexion and Extension, Toe Flexion and Extension, Ankle Flexion and Extension, Hip Abduction and Adduction (out and in). Exercises should be done 2-3 times per day with 10-20 reps." The form had highlighted area stated, "Do all movements slowly and smoothly. Don't force the body to move beyond its comfortable range." R93's nursing assistant care sheet updated 6/6/24, failed to include passive range of motion exercises to be provided to resident and what cares were needed for the right contracted hand. During interview with nursing assistant (NA)-B on 6/10/24 at 1:36 p.m., NA-B stated he was full time employee and worked over fifteen years at facility and familiar with R93. NA-B stated, "I don't know anything about helping with R93's exercises. It should be on the care sheet and care plan for me to do. I don't' know anything about a splint for R93's hand . NA-B stated he was unaware of why there was a rolled up washcloth in R93's right hand. During observation on 6/11/24 at 8:24 a.m., R93 in bed wearing hospital gown. Right hand with rolled up washcloth in it.	F 688		

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F 688	Continued From page 44 During interview with licensed practical nurse (LPN)-A on 6/11/24 at 8:38 a.m., LPN-A stated she was familiar with R93 and was unaware why the washcloth was in his hand. LPN-A verified they were not in the care plan or orders and should be. During interview with NA-F on 6/12/24 at 7:45 a.m., NA-F verified being familiar with R93's wing and PROM was to be completed daily. NA-F was not aware of the washcloth or who placed it. During observation on 6/12/24 at 8:16 a.m., R93 laying in bed wearing hospital gown. Right hand with rolled up washcloth in it. During interview with occupational therapist (OT) on 6/12/24 at 9:45 a.m., OT stated PROM exercises are recommended for all residents with hand and limb contractures to prevent decline in mobility. OT stated therapy orders and recommendations are provided to the nurse manager on the unit once each residents is assessed on admission and as needed per physician order. The exercises are then posted with instructions to post on the closet door of each resident for staff to refer to when performing the daily exercises. Then, the nurse manager will update nursing assistant care sheets and the resident care plan to implement the PROM and other recommendations. OT looked in R93's EMR and stated, "[I] don't know anything about a washcloth rolled up in [R93's] hand." Also, OT stated R93s EMR failed to identify what PROM exercises were recommended. During interview with the director of therapy (DT) on 6/12/24 at 10:17 a.m., DT stated all residents are seen for therapy evaluations upon admission.	F 688		

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F 688	Continued From page 45 "If [they have] contractures like R93, we find out if they had a splint [prior to admission] and assess them for it". DT stated R93 "is non verbal so they [therapy] rely on family and nurses to determine if R93 tolerates it". DT looked in R93's EMR and stated, "I would recommend a palm guard or rolled up washcloth [to R93's right hand]. I would expect that to be in his [R93's] care plan [and care sheets] to let staff know what to do with his hand". DT stated R93's care plan, orders, and care sheets did not have interventions to perform PROM or apply a washcloth or splint to R93's right hand. DT stated, "I don't see it and it should be [in R93's EMR]." During interview with registered nurse (RN)-D on 6/12/24 at 11:22 a.m., RN-D stated, "yes, he [R93} has a hand splint. All of this [including PROM exercises] should be in the care plan [sic] for staff to know what to do." RN-D looked in R93's EMR and stated, "it should be in [R93's] care plan. I don't see anything in his chart to tell staff about his hand splint [and PROM]". During interview with family member (FM)-A on 6/12/24 at 11:15 a.m., FM-A stated he was R93's primary emergency contact, "[R93] had a splint to right hand. He had one but I don't know if he still has one. I haven't seen it for along time. In fact, I don't know if he still has it." FM-A stated facility had not communicated with him "in the past year" about the contracture to R93's right hand. Also, FM-A stated he was unaware of R93 receiving any form of PROM exercises, and "he should". During interview with director of nursing (DON) on 6/13/24 at 2:49 a.m., DON stated R93's EMR failed to address PROM and splint use or palm guard. DON stated, "these should be in there for	F 688		

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F 688	Continued From page 46 staff to know what to do and when." R93 paper form received by DT to surveyor and downloaded on 6/13/24 at 11:26 a.m., titled Splint and ROM Implementation Timeline indicate occupational therapy recommended on 4/19/22, "PROM established and paper copy with instructions provided to nursing-splinting not indicated due to pts noncompliance with splint assessment and trials". Form also indicated on 4/15/22 physical therapy established a PROM for R93 and, "paper copy with instructions provided to nursing". R108's quarterly Minimum Data Sat (MDS) assessment, dated 5/14/24, indicated R108 had severe cognitive impairment, had no impairment to her upper or lower extremities and required partial to moderate assistance with activities of daily living (ADLs) including ambulation. R108's physician order, dated 4/25/24, directed staff to walk R108 three times a day to meals using a four wheeled walker. R108's care plan, dated 6/5/24, indicated R108 should be walked to meals three times a day using a four wheeled walker per therapy. R108's care sheet, printed 6/12/24, indicated the nursing assistants were to walk R108 three times a day to meals using a four wheeled walker. R108's Tasks documentation for the nursing assistance for the month of June indicated R108 walking in the unit hallway was documented as "not applicable."	F 688		

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F 688	Continued From page 47 During observation on 6/12/24 at 7:10 a.m., R108 was sitting out in the main dining area in her wheelchair, waiting for breakfast. During an interview on 6/12/24 at 7:15 a.m., nursing assistance (NA)-J stated the nursing assistants use the care sheets to know what cares to provide the residents. NA-J confirmed R108 can walk but was wheeled out in her wheelchair to the breakfast table after morning cares. During observation on 6/12/24 at 9:16 a.m., R108 was wheeled away from the dining room table and wheeled into her room. During an interview on 6/12/24 at 2:04 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated the expectation was for the nursing assistants to follow the care sheets and walk R108 to meals. LPN-D confirmed the aides were not walking R108 to meals stating, "they need to be better at that" to help R108 maintain her mobility. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) confirmed it would be expected that the nursing assistants are following the care sheets and walking R108 to meals every day. A facility polity titled Activities of Daily Living (ADLs)/Maintain Abilities Policy updated 5/9/24, state "the facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living."	F 688		
F 697 SS=D	Pain Management	F 697		7/17/24

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F 697	Continued From page 48 CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pain with mobility (i.e., repositioning) was appropriately monitored and comprehensively re-assessed then, if needed, interventions developed to promote comfort with mobility for 1 of 2 residents (R92) reviewed for pain management. Findings include: R92's Medicare - 5 Day Minimum Data Set (MDS) assessment, dated 5/10/24, identified R92 had intact cognition and demonstrated no delusional thinking. The MDS outlined R92 consumed scheduled and as-needed (i.e., PRN) pain medication, however, did not receive any non-pharmacological interventions during the review period. The MDS recorded R92's pain interview responses (i.e., J0300 to J0600) as, "Not assessed." R92's most recent MHM (Monarch Healthcare Management) Pain Evaluation - V3, dated 3/21/24, identified R92 consumed scheduled pain medication; however, did not receive any PRN medication or non-pharmacological interventions for pain. The evaluation outlined a pain interview was completed with R92 who denied pain or hurting during the five-day period adding a rating	F 697	F697 1.R92 pain management was reviewed by the pain provider. Order in place for licensed staff to document pain specific site and utilize non-pharmacologic interventions as needed. 2. All residents currently followed by in-house pain MD will be reviewed to ensure monitoring is in place on orders, non-pharmacologic interventions are in place if applicable and the current pain management plan is effective. New pain assessments will be completed for residents being seen by in-house pain MD. 3. All licensed nursing staff will be educated about pain management and using non-pharmacologic intervention as needed. 4. Audits will be completed of resident with pain management to ensure pain management is effective. Five audits per week x4 weeks. Then each audit will be completed one weekly x4 weeks.	

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F 697	Continued From page 49 recorded as, "00." The evaluation listed a section labeled, "Been on a scheduled pain medication regimen[?]," which was marked and listed a corresponding section to complete, "Describe treatment, any side effects and effectiveness." However, the section was completed only with, "Butrans, lidocaine patch, Biofreeze," and lacked any recorded information on if these were effective or not, including with R92's input. A subsequent section labeled, "Comments," outlined dictation which read, "Resident stated that he does not have pain when he is laying down ... his pain only occurs when he is hoyered and traveling." The completed evaluation lacked any further assessment of the pain with mobility (i.e., characteristics) or what, if any, additional actions were being taken for it despite it being identified with the current medication regimen listed. R92's care plan, identified R92 had an alteration in comfort and listed a goal which read, "Resident will have adequate relief from pain ... freedom from signs/symptoms [sic] of non-verbal indicators of pain." The care plan listed multiple interventions for this including providing non-medicinal forms of pain relief, giving pain medication as ordered, and encouraging him to verbalize pain. On 6/10/24 at 1:38 p.m., R92 was observed lying in bed while in his room and demonstrated no obvious physical signs or symptoms of pain (i.e., grimace, moaning). R92 was interviewed, and explained his knees were "completely wrecked" which caused him moderate pain adding, "I hurt a lot all the time." R92 stated he was taking some medications for the pain, including Tylenol and a patch which "starts with a B" but they were not	F 697	5.The results will then be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Audits will be completed by DON or designee.	

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F 697	Continued From page 50 effective, and the pain remained. R92 stated they staff were aware he had pain but just respond to him saying there was nothing they could do. R92 reiterated he would like to know what, if any, other options existed for his pain (i.e., non-pharms, stronger medications) and expressed the medications and patches were "not really doing anything." R92's Medication Administration Record (MAR), dated 6/2024, identified R92's consumed and recorded medications for the month period. These outlined orders included: "Butrans ... 5 MCG/HR ... 1 patch transdermally ... every Wed ...," with a listed start date, "05/22/2024." A corresponding, "Pain Level," was listed for each weekly application and all of them, so far, were recorded, "0." "Diclofenac Sodium External Gel 1% ... Apply to both knees topically two times a day ...," with a listed start date, "05/01/2024." A corresponding, "Pain Level," was recorded with each administration and, again, all of which were recorded, "0." R92's Nursing Home Visit (note), dated 5/1/24, identified R92 was seen by the nurse practitioner (NP) with a chief complaint listed, "Chronic Pain." The note identified R92 had chronic pain syndrome, polyneuropathy, and osteoarthritis. A section labeled, "Plan," outlined R92's pain management was discussed with him and the Butrans patch prescription was renewed, and Diclofenac gel (a topical pain relief gel) was started. The note listed R92's Butrans 5 micrograms (mcg)/hr applied weekly with notation, "Could increase dose if needed in the	F 697		

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F 697	Continued From page 51 future," along with evidence of past medications tried which caused side effects or were ineffective. The note included, "Closely monitoring for pain at rest and with activity; Please notify physician if new onset of pain symptoms begin." On 6/12/24 at 9:41 a.m., nursing assistant (NA)-D was interviewed. NA-D verified they had worked with R92 multiple times prior and described him as needing "100% total" help with cares and mobility. NA-D stated R92 needed help to reposition in bed and would "sometimes" get up from bed using a mechanical lift. NA-D stated R92 seemed "pretty comfortable," however, did still complain of pain with repositioning and if getting up from bed adding it had been like that "for a little while now." NA-D explained R92 had recently worked with therapy but couldn't tolerate it well as with mobility then, "He [R92] will start to talk about pain, pain." NA-D stated they believed the nurses were aware of R92's pain with mobility (i.e., transfers) and repositioning. R92's subsequent Nursing Home Visit (note), dated 5/20/24, identified R92 was seen by the physician and, again, listed a chief complaint of, "Chronic Pain." R92 was recorded as being seen while lying in bed and reporting to have bilateral knee pain " ... which is intermittent," and there were no concerns reported by nursing or therapy staff. A section labeled, "Plan," identified R92's Butrans prescription was renewed and again included dictation, "Could increase dose if needed in the future." R92's remaining medications were continued at the same doses; however, the note lacked evidence R92's specific pain with mobility and repositioning had been evaluated or discussed with him.	F 697		

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F 697	Continued From page 52 In addition, R92's medical record was reviewed and lacked evidence R92 had been comprehensively reassessed for his pain management and what, if any, interventions had been evaluated or offered to reduce his pain with mobility-related activities despite R92 having continued, ongoing complaints of pain witnessed by the floor staff and recent medication changes (i.e., 5/1/24). Further, there was no recorded evidence a comprehensive evaluation had been conducted by the care center (i.e., MHM Pain Evaluation) to ensure R92's pain was being accurately tracked and monitored despite known, ongoing pain with mobility (i.e., only "0" recorded despite pain being identified). When interviewed on 6/12/24 at 11:58 a.m., registered nurse (RN)-F explained they had worked with R92 multiple times and he needed total assistance for cares adding, "We do everything for him." RN-F stated R92 was able to report any complaints he had, including pain, but expressed such complaints were "very rare" to their knowledge. RN-F stated R92 did still get up to his wheelchair, at times, but could only handle "very few minutes" before wanting to go back to bed adding they were unsure if it was pain-related or not. RN-F stated they ask R92 for his pain when they apply his patches, and expressed they were unaware R92 was expressing pain with repositioning. RN-F stated a comprehensive assessment of R92's pain, including after medication changes, was not typically done by the floor staff adding, "Maybe the manger, I don't know." On 6/13/24 at 1:28 p.m., the director of nursing (DON) was interviewed. DON explained they had	F 697		

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F 697	Continued From page 53 just prior gone and repeated the MHM Pain Evaluation - V3 for R92 and he did endorse having pain with repositioning, peri-cares, and transfers. DON explained the evaluation was typically done on a quarterly basis but if pain was "consistently happening" then it should have been repeated. DON reviewed R92's MAR and stated the "pain level" recordings were used to help monitor for pain and if the NA staff were hearing or seeing pain, including with mobility, then it should be reported to the nurse and "they will do an assessment" and capture it. DON stated R92 was under current service from the pain management physician and the nurse manager for R92's unit was on LOA, but they verified they couldn't locate documented evidence R92's pain with mobility-related activities had been comprehensively assessed in their medical record. DON stated it was important to ensure pain, including with specific activities, was assessed and accurately monitored to ensure appropriate medication management adding, "It's important." A provided Pain Management Protocol policy, dated 3/2023, identified the care center would have an effective pain management plan in place for residents. It defined this as, " ... the process of alleviating the resident's pain to a level that is acceptable to the resident ... based on her and her [sic] clinical condition and established treatment goals." The policy directed the interdisciplinary team (IDT) would identify residents with acute or chronic pain to establish a plan; and nursing would evaluate for pain upon admission, quarterly and if newly onset pain or worsening pain was identified. The policy added, "The nursing staff will identify any situations or interventions where an increase in the resident's	F 697		

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THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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F 697	Continued From page 54 pain may be anticipated, for example wound care, ambulation, or repositioning." Further, the policy outlined monitoring of pain would be reassessed at regular intervals to ensure it was controlled and the regimen effective adding, "Review should include frequency and intensity of pain, ability to perform activities of daily living (ADLs), sleep pattern, mood, behavior, and participation in activities." Any significant changes in levels of comfort would be discussed with the provider.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure post-dialysis access site monitoring was consistently completed and documented to provide continuity of care and reduce the risk of complication (i.e., bleeding, infection) for 1 of 1 resident (R49) reviewed for dialysis care and services. Findings include: R49's quarterly Minimum Data Set (MDS) assessment dated 5/15/24, indicated R49 had moderate cognitive impairment and demonstrated no rejection of care behavior. The MDS indicated R49 was diagnosed with kidney disease with dialysis treatment and a stroke with aphasia (a disorder affecting speech). The MDS indicated	F 698	F698 1.R49 Dialysis access site monitoring order in place for licensed nurse to monitor every shift. 2. Residents with dialysis sites have the potential to be affected. All residents with dialysis access sites will be reviewed and monitoring will be in place. 3. All licensed nursing staff will be educated about the importance of monitoring dialysis access sites of the residents and documenting. 4.Audits will be completed of resident	7/17/24

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F 698	Continued From page 55 R49 was able to independently wheel 50 feet, required set-up help for eating, and was dependent on staff for transfers. R49's Order Summary Report dated 6/22/23, indicated an order to monitor for "bruit (whooshing sound) and a thrill (a powerful pulse felt at the top of the fistula) every shift. An order dated 6/13/24, indicated nursing staff should monitor and view the dialysis site to the left chest for bleeding and signs and symptoms of infection every shift. An order dated 6/12/24, indicated nursing staff should monitor "dialysis site for bleeding" every shift. R49's hospital After Visit Summary dated 12/20/23, indicated R49 had his central venous catheter (CVC) exchanged and new orders could be found in the discharge instructions. The discharge instructions indicated the CVC insertion site should be checked at least daily for signs and symptoms of infection such as redness, swelling, drainage, or tenderness. The discharge instructions indicated the CVC should be assessed every day to ensure the clamps were tightly secured over both ends of the tubing. R49's care plan dated 4/19/24, indicated R49 was at risk for injury from dialysis related to possible clotting, hemorrhaging, accidental disconnection, or infection. The care plan indicated that R49 received dialysis at an offsite clinic on Monday, Wednesday, and Friday. The care plan indicated that R49 had a fistula on his right upper extremity but did not indicate that R49 had a CVC on the left chest. The care plan listed several interventions for R49 including: "check extremity access daily for warmth, redness, and signs of infection", chest fistula for thrill and bruit, if	F 698	dialysis access sites monitoring in place at 5 audits per week x4 weeks. Then each audit will be completed once weekly x4 weeks. 5. Results of audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Audits will be completed by DON or designee.	

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F 698	Continued From page 56 bleeding occurs apply pressure with clean gauze for 10 to 15 minutes, if not controlled call 911, notify the physician of edema, chest pain, elevated blood pressure, or shortness of breath, monitor dialysis site for bleeding, and nursing was to complete the pre-dialysis and post-dialysis assessment. R49's dialysis Treatment Details Report dated 6/5/24, indicated R49 received dialysis at an offsite clinic through a tunneled CVC in his left chest. R49's administration record dated 5/1/24 through 6/11/24, did not indicate daily assessments were completed on the CVC used for dialysis. During an interview on 6/12/24 at 9:57 a.m., registered nurse (RN)-B stated R49's right fistula had closed in the past and a dialysis catheter had been placed on R49's left chest. RN-B stated she referenced the orders to know when to assess the dialysis catheter. RN-B stated this was usually documented in the treatment administration record (TAR) when these assessments were completed. RN-B stated R49 had the dialysis catheter for "a while" so she was unsure why there was not an order to monitor the catheter as all she saw was an order to continue monitoring the fistula. RN-B stated she had worked with R49 frequently so she knew about the CVC but she did not see an order for monitoring it. RN-B stated she was unsure how someone new to R49 would know to monitor the site or where it was since there was not an order in. During an interview on 6/12/24 at 1:58 p.m., RN-E, the nurse manager for the unit, stated she would expect an order to be present in the	F 698		

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F 698	Continued From page 57 medical record so nursing staff would know where the dialysis catheter was, what to monitor it for, and how often to monitor the site. RN-E stated it was important nursing staff were monitoring for signs and symptoms of infection as well as for bleeding every shift and when the resident came back from dialysis to prevent possible complications. During an interview and observation on 6/13/24 at 12:11 p.m., licensed practical nurse (LPN)-C stated he was the nurse in charge of R49's care. LPN-C stated he had not assessed R49's dialysis site yet today. LPN-C was observed to assess R49's left extremity. LPN-C stated he was "not exactly sure" where the dialysis site was. LPN-C was then observed to adjust R49's shirt so the dialysis site was viewed on the left chest. During an interview on 6/13/24 at 1:43 p.m., the director of nursing (DON) stated it was important the dialysis catheter was assessed daily for signs and symptoms of infection as well as bleeding and this should be shown in the administration record. The facility's Hemodialysis policy dated 11/22/19, indicated documentation requirements included daily checks of the access dialysis access site and evaluation for signs and symptoms of infection.	F 698		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with	F 699		7/17/24

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F 699	Continued From page 58 professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess history of past trauma and implement care plan interventions to identify triggers for 1 of 1 residents reviewed (R18) whose diagnoses included post-traumatic stress disorder (PTSD). Findings include: R18's annual Minimum Data Set (MDS) assessment dated 4/4/24 identified admission to facility on 4/12/23, intact cognition, and diagnoses of seizure disorder, anxiety, depression, schizophrenia, bipolar disorder, and PTSD. R18's care plan (CP) goal dated 4/27/22 indicated, Resident has PTSD, R 18's mother was abusive and she was a victim of sexual assault in 1970, which may have resulted in pregnancy & a coma. R18 interventions included, Staff will utilize trauma informed care when working with resident, Staff will consider past trauma when engaging in work with resident, Consider past trauma when engaging with resident. R18's care plan lacked identified triggers to avoid re-traumatization. R18's nursing assistant care sheet, updated 6/6/24 failed to identify PTSD diagnoses and triggers.	F 699	F699 1.Triggers were added to R18's care plan for PTSD. The care sheet for R18 was updated to include PTSD diagnosis and triggers for PTSD. 2. Residents with PTSD have the potential to be affected by this practice. Residents with a dx of PTSD will be reviewed to ensure triggers voiced are added to care plan and care sheets. 3. Social services staff will be educated on asking residents with a diagnosis of PTSD what their triggers are, adding triggers and how they can be avoided to the care plan and care sheets. Education for nursing staff where they can find out if a resident has PTSD and what their triggers are and how they can be avoided. If a resident with PTSD does not have any self-reported triggers for PTSD, this will also be outlined in the care plan and care sheet. 4.Audits of any new residents with a diagnosis of PTSD will be completed as well as 5 audits per week x4 weeks for any residents with a current diagnosis of PTSD. Then each audit will be completed once weekly x4 weeks.	

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F 699	Continued From page 59 During interview with R18 on 6/10/24 at 5:41 p.m., R18 stated she had not been asked about their PTSD. R18 stated her triggers included, "harsh tones", "yelling", and "raised voices". During interview with director of nursing (DON) and facility administrator on 6/10/24 at 6:25 p.m., the administrator stated trauma assessments were the responsibility of the social worker and are reflected in the electronic medical record. During an interview with nursing assistant (NA)-G on 6/11/24 at 1:07 p.m., stated he was familiar with R18. NA-G stated nursing assistant care sheets provide staff guidance on every residents needs such as transfer assistance, hearing aide/glasses/denture needs, grooming, toileting, days to weigh the resident, therapy schedules and skin care, including special needs/behavior monitoring. NA-G stated the care sheet is where he would expect triggers to be listed. NA-G verified PTSD is not listed on the care sheets. NA-G mentioned they would have to be told about what triggers R18 past trauma in order to avoid them for R18. During interview with registered nurse (RN)-D on 6/11/24 at 2:27 p.m., RN-D stated she was unable to locate what triggers R18 of her past trauma in R18 care plan and was important to know what they were. During interview with RN-C on 6/11/24 at 2:53 p.m., RN-C stated, "PTSD history [sic] very sensitive to certain triggers [sic]. I expect triggers to be addressed so not to re-traumatize the resident". RN-C reviewed R18's EMR and stated, "[R18's] care plan does not show what her triggers are so we do not know what to avoid or	F 699	5. Results will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Audits will be brought to QAPI by SSD or designee.	

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F 699	Continued From page 60 address." During interview with NA-F on 6/12/24 at 7:45 a.m., NA-F stated she was full time employee and worked primarily on unit with R18. NA-F stated, "it is important to know what triggers are to avoid." NA-F stated expectation of resident trauma triggers, "should be in the care plan [sic] care sheets". NA-F looked at R18's care sheet and care plan and stated, "[it] doesn't say anything about her triggers" and as for R18's care sheet, "I don't see anything about her having any kind of trauma". NA-F stated the nursing assistant care sheet is where she would expect to see anything about triggers to avoid. During interview with DON on 6/13/24 at 8:20 a.m., DON stated, "When someone has PTSD we should be looking at what the source of the trauma is. Care plan[s] should have triggers. [R18] care plan does not have triggers and it should." DON stated R18's care plan interventions, "is generic and not patient specific. The staff are not going to know what behaviors or actions to avoid [sic] prevent re-traumatization." During interview with social worker director (SS)-D on 6/13/24 at 10:05 a.m., SS-D stated expectation of the social work department to fill out a trauma questionnaire on "Admission and prn". SS-D stated, "if they [residents] say they ar a trauma victim or [sic] PTSD, we put in trauma care plan and ACP (psychiatry) referral". SS-D looked in R18's EMR and stated, "[R18] care plan interventions do not identify her triggers." Facility policy titled Trauma Informed Care dated 2/24/23, state "Residents that have a history of trauma will have goals and interventions added to	F 699		

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F 699	Continued From page 61 their care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident."	F 699		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly	F 756		7/17/24

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F 756	Continued From page 62 drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address and respond to the consulting pharmacist's (CP) medication regiment review (MRR) for 2 of 5 residents (R75 and R83) receiving psychotropics (a psychoactive medication taken to exert an effect on the chemical makeup of the brain and nervous system) reviewed for unnecessary medications. Findings include: R75's quarterly Minimum Data Set (MDS) assessment, dated 5/9/24, indicated R75 was admitted to the facility on 1/14/21, had severe cognitive impairment, was independent with ambulation and was receiving the following medications during the look back period; antipsychotics, antianxiety, antidepressants, and opioids. R75's MRR, dated 4/26/24, indicated it was unclear if R75's falls were related to medication and recommended considering reducing R75's Hydroxyzine order to 25 mg at 2:00 p.m. The report included: R75 had multiple falls within the past month and was receiving the following medications that may increase fall risk; Citalopram 20 milligrams (mg) daily (a medication used to treat depression, including major depressive disorder), Hydroxyzine 50 mg three times a day (a medication used to treat anxiety, nausea, vomiting, allergies, skin rash, hives, and	F 756	F756 1.R83 antipsychotic medication diagnosis was updated. R75 order was reviewed and updated. 2. Residents using psychoactive medications have the potential to be affected. 3.Nursing leaders will be educated about the importance of pharmacy recommendations and prompt follow-up. DON will be distributing the pharmacy recommendations monthly to the nurse leaders. DON will be meeting with the nurse leaders after 2 weeks to follow up with the recommendations. Pharmacy recommendations will be uploaded in resident medical records upon completion. 4. Audits will be completed of resident with pharmacy recommendations to ensure compliance. Five audits per week x4 weeks. Then each audit will be completed once week x4 weeks. 5. Audits will be brought to QAPI by DON or designee. Results will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits.	

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F 756	Continued From page 63 itching), Lisinopril 5 mg daily (a medication used to treat high blood pressure and heart failure), Seroquel 50 mg twice a day (a psychotropic medication used to treat schizophrenia and bipolar disorder), and Lorazepam 1 mg daily (a benzodiazepine used to treat anxiety). R75's electronic medical record (EMR), including the MRR, lacked evidence of physician or prescriber response or follow-up. R75's care plan, dated 4/1/24 - 6/13/24, indicated R75 had five falls on the following dates; 5/26/24 (lowered to the floor due to perceived dizziness), 5/15/24, 5/13/24, 4/24/24, and 4/11/24. R83's quarterly MDS assessment, dated 3/12/24, indicated R83 was admitted to the facility on 11/17/23, had severe cognitive impairment, was independent with ambulation, and received the following medications during the look back period; antipsychotics and antidepressants. R83's Medical Diagnoses, printed 6/13/24, indicated R83 had several medical diagnoses including unspecified dementia with behavioral disturbances, atrial fibrillation, hypertension, chronic kidney disease, atherosclerotic heart disease, major depressive disorder, generalized anxiety, presence of cardiac pacemaker, obesity, fatigue and personal history of transient ischemic attack and cerebral infarction without deficits. R83's MRR, dated 4/26/24, indicated, the Seroquel lacked an appropriate diagnosis, indicating dementia with behavioral disturbances but lacked psychotic features of dementia (i.e., hallucinations, paranoia, delusions) and a review of whether antipsychotic use was necessary. The	F 756		

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F 756	Continued From page 64 report included: R83 was receiving the following medications; Seroquel 25 mg three times a day, Mirtazapine 7.5 mg every evening (an antidepressant used to treat depression), and Depakote extended release 125 mg daily and 500mg every evening (an anticonvulsant used to treat seizures and bipolar disorder). R83's order for Seroquel, dated 5/14/24, indicated R83 was receiving Seroquel for schizophrenia. R83's EMR lacked documented evidence of provider/prescriber follow up or response on the necessity of antipsychotic use. R83's MRR, dated 5/24/24, indicated to clarify the indication of Seroquel use as it was changed to Schizophrenia and R83 lacked an actual documented diagnosis of Schizophrenia. R83's EMR lacked evidence of a follow up response. During an interview on 6/13/24 at 12:35 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated each director of nursing (DON) had their own process for addressing the MRR's. LPN-D stated the current process was for the DON to send the CP's MRR's to the clinical coordinators via email. If the recommendation was nursing related (i.e., orthostatic blood pressures, target behaviors) the clinical coordinator would address it. If the recommendation was for the provider (i.e., changing medication orders or diagnoses) the MRR was put into the provider mailbox for addressing. CONSULTANT PHARMACIST WAS CALLED TWICE WITH NO RESPONSE During an interview on 6/13/24 at 1:51 p.m., the	F 756		

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F 756	Continued From page 65 director of nursing (DON) stated they were aware the process for MRR's was not working, stating with turnover of the health unit coordinator the MRR forms were ending up in the wrong box leading to MRR follow up being missed. A facility policy titled Medication Regiment Review, dated August 2019, indicated MRR recommendations would be documented and acted upon by the facility staff and/or prescriber, indicating the prescriber would accept and act upon the suggestion or reject the suggestion and provide an explanation for disagreeing.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		7/17/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 66 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident taking an antipsychotic medication had an appropriate diagnosis for use and was monitored for target behaviors for 1 of 5 residents (R83) reviewed for unnecessary medications. Findings include: R83's quarterly Minimum Data Set (MDS), dated 3/12/24, indicated R83 was admitted to the facility on 11/17/23, had severe cognitive impairment, was independent with ambulation, and received	F 758	F758 1.R83 appropriate diagnosis was updated and target behavior in place. 2. Residents with cognitive impairment and using psychotropic medications have the potential to be affected. Residents on psychotropic medications will be reviewed and target behavior monitoring added. 3.Licensed nurses will be educated to monitor and document resident target behavior. IDT will meet and review	

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F 758	Continued From page 67 the following medications during the look back period; antipsychotics and antidepressants. R83's Medical Diagnoses, indicated R83 diagnoses including dementia with behavioral disturbances, major depressive disorder, generalized anxiety. R83's electronic medical record (EMR) lacked evidence of resident specific target behaviors or monitoring for behaviors, R83's MRR, dated 4/26/24, indicated R83 was receiving the following medications; Seroquel 25 mg three times a day, Mirtazapine 7.5 mg every evening (an antidepressant used to treat depression), and Depakote extended release 125 mg daily and 500mg every evening (an anticonvulsant used to treat seizures and bipolar disorder). The MRR indicated the Seroquel lacked an appropriate diagnosis, indicating dementia with behavioral disturbances but lacked psychotic features of dementia (i.e., hallucinations, paranoia, delusions). The MRR requested a review of whether antipsychotic use was necessary. R83's order for Seroquel, dated 5/14/24, indicated R83 was receiving Seroquel for schizophrenia. R83's EMR lacked documented evidence of provider/prescriber follow up or response on the necessity of antipsychotic use. R83's MRR, dated 5/24/24, indicated to clarify the indication of Seroquel use as it was changed to Schizophrenia and R83 lacked an actual documented diagnosis of Schizophrenia. R83's EMR lacked evidence of a follow up response.	F 758	monthly behavior for appropriate psychotropic use. 4.Audits will be completed of target behaviors to ensure proper use and diagnosis at 5 audits per week x4 weeks. Then each audit will be completed one weekly x4 weeks. 5. Audits will be brought to QAPI by DON or designee. Results will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits.	

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F 758	Continued From page 68 During an interview on 6/13/24 at 12:35 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated each director of nursing (DON) had their own process for addressing the MRR's. LPN-D stated the current process was for the DON to send the CP's MRR's to the clinical coordinators via email. If the recommendation was nursing related (i.e., orthostatic blood pressures, target behaviors) the clinical coordinator would address it. If the recommendation was for the provider (i.e., changing medication orders or diagnoses) the MRR was put into the provider mailbox for addressing. LPN-D confirmed R83's EMR was missing target behaviors monitoring which is important in monitoring if an antipsychotic medication is effective. CONSULTANT PHARMACIST WAS CALLED TWICE WITH NO RESPONSE During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) stated they were aware the process for MRR's was not working, stating with turnover of the health unit coordinator the MRR forms were ending up in the wrong box leading to MRR follow up being missed. A facility policy titled Psychotropic Medication Use, undated, indicated, "residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective" and "the Interdisciplinary team and the primary provider will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others."	F 758		

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F 761	Continued From page 69	F 761		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §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, facility failed to ensure mediations were kept locked or under direct observation of authorized staff in areas where residents, staff and visitors could access medications. The deficient practice had the potential to affect 32 current residents on the unit. Findings include:	F 761	F761 1.Immediate training to involved staff and audit were done to ensure that all 2S medication carts were locked. 2. Residents receiving medication on all units have the potential to be affected. 3.Licensed nurses and nurse leaders on all floors will be educated in the	7/17/24

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F 761	Continued From page 70 During observation on 6/10/24 at 5:35 p.m., at entrance of the 2S dining room there was an unlocked medication cart. Dining room had 12 residents in the room eating dinner and numerous staff walking past the medication cart transporting residents. During observation and interview with registered nurse (RN)-C on 6/10/24 at 5:36 p.m., RN-C walked up to the unattended medication cart and locked the cart. RN-C stated, "nurses should be sure the med carts are locked and laptop should be closed due to privacy". RN-C stated the nurse responsible for the unattended medication cart was not "in the area" and would try to locate them. During interview with licensed practical nurse (LPN)-B on 6/10/24 at 5:37 p.m., LPN-B stated he was responsible for the unattended medication cart and, "it is a violation. I should lock it [medication cart] when I leave the cart." And, "so no one can get in the medication cart here." During interview with director of nursing (DON) on 6/11/24 at 9:11 a.m., DON stated, "medication carts should always be locked when staff step away from the cart. Because there are some meds in the carts that should not be available to residents." Facility policy on medication storage was requested and not received.	F 761	importance of locking carts. 4. Audits will be completed of all unit medication carts. Five audits per week x4 weeks. Then each audit will be completed once weekly x4 weeks. The results will then be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. 5.Audits will be brought to QAPI by DON or designee.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		7/17/24

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F 880	Continued From page 71 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national 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	F 880		

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F 880	Continued From page 72 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to utilize infection control practices while administering medications through gastrostomy tube for 1 of 1 residents (R93) observed for medication administration, utilize infection control practices while delivering meal trays to resident rooms for 7 of 7 residents (R35, R53, R58, R59, R64, R67, R112) observed for dining, while assisting multiple residents to eat at once for 7 of 33 residents (R2, R3, R14,R23, R33, R55, R80) observed for dining. In addition, the facility failed to implement and maintain enhanced barrier precautions (EBP) for 2 of 2 resident (R16, R93) reviewed for transmission	F 880	F880 1. R93 Immediate education done to involved license staff. R93 was assessed and not affected by this practice. R16 wound was resolved and no longer on EBP. R35, R53, R58,R59, R64, R67, R112 were assessed and do not seem to be affected by this practice. R2, R3, R14, R23, R33, 55, R80 were assessed and do not seem to be affected by this practice. Trash bins are available inside the resident side of room for both residents on EBP. Specific EBP is communicated	

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F 880	Continued From page 73 based precautions. Furthermore, the facility failed to mitigate transmission of potential infections in relation to laundering of linens and personal items. Findings include: Med Admin R93 R93's quarterly Minimum Data Set (MDS) dated 3/28/24 state admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's physician orders (PO) dated 4/8/22 direct staff to, "Crush each medication in 15ml of warm purified or sterile water and administer each separately using gravity." R93's PO dated 4/22/24 stated, "Before administering medication, stop feeding for 30 minutes and flush the tube with at least 15 milliliters (mL) sterile water." During observation on 6/12/24 at 8:16 a.m., licensed practical nurse (LPN)-A entered R93's room with four medication cups of crushed medications and placed them on his bedside table. LPN-A then obtained the sixty cubic centimeter (cc) piston syringe from his bedside table and added water from a plastic cylinder into each medication cup. LPN-A then paused R93's enteral feeding that was running and removed his abdominal binder to access his GT. LPN-A then auscultated and assessed R93's GT for placement by connecting piston syringe with water in it to R93's GT port and injecting and	F 880	to EMAR and Care sheet for staff communication. Laundry routine was updated and implemented during the week of survey. 2. Residents on EBP have the potential to be affected and residents during meals. Residents who have their laundry done at the facility have the potential to be affected. 3. Review dining placement and assistance during meals to avoid cross contamination. Sani wipes will be available in the dining area for staff to disinfect hands before and after helping each resident. Sani wipes will be available in the food cart for staff to disinfect hands before and after passing trays. The laundry routine was updated. 4. Nursing staff will be educated on infection control and prevention policy, following enhanced barrier precautions and handwashing to prevent spread of infection. Education for licensed staff on replacing piston syringes daily and as needed if contaminated. Specific residents under EBP will be communicated through EMR and care sheet. Education will be completed with laundry staff about not leaving clothes in the wash overnight. Residents who come of off EBP will have appropriate documentation noted in PCC. 5.Audits will be completed of residents on EPB to ensure staff are following appropriate infection control, trash can in	

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F 880	Continued From page 74 withdrawing water. LPN-A then disconnected piston syringe from GT port and bent the tubing connected to the resident with her left hand while reaching over to the bedside table and aspirating (withdrawing) medication mixture from one medication cup with her right hand. LPN-A then connected the medication filled piston syringe to the GT port and unbent the GT that was attached to R93. LPN-A then administered medication and bent the GT with left hand and reached over to the bedside table to withdraw another medication. During this process LPN-A allowed the tip of the piston syringe to touch R93's hospital gown several times and used the piston syringe to add more water to the next medication cup. LPN-A then withdrew it into the piston syringe and repeated process until all four medications were administered. During administration LPN-A allowed the tip of the piston syringe to touch R93's hospital gown again before adding more water to the piston syringe and flushing the GT port to end the process. LPN-A re-connected enteral feeding tube and re-applied R93's abdominal binder. During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated she had not turned off R93's enteral feeding for thirty minutes prior to administering his medications per PO and, "I should have". Also, "the piston syringe should never touch the resident gown when administering GT meds. Contamination is a concern." During interview with director of nursing (DON) on 6/11/24 at 9:08 a.m., DON stated, "GT feeding tip of piston syringe should not touch gown of resident due to risk of contamination. Staff should [have] replaced it and [sic] get a new one if the	F 880	place, signage is on door and staff know how to find the reason why someone is on EBP. Audits will be conducted during mealtime to ensure staff are sanitizing hands appropriately. Audits will be completed of residents needing assistance with meals to ensure staff are sanitizing hands in between residents. Audits will be completed to ensure laundry is not left in the wash overnight. All audits will be completed at 5x per week x4 weeks. Then each audit will be completed once per week x4 weeks. 6. All audits will be brought to facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits. Audits will be brought to QAPI by DON or designee.	

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F 880	Continued From page 75 end touches anything like the gown of a resident." Facility policy titled Administering Medications through an Enteral Tube updated 3/23/23, "stop the feeding at least 30 minutes prior to medication administration and restart at least 30 minutes after medication administration." And, "Place the end of the tubing on a clean gauze pad positioned on the abdomen or chest of the resident". EBP R16 R16's quarterly MDS dated 4/16/24, stated admission to facility on 12/14/23, had intact cognition, and diagnoses of coronary artery disease (CAD), heart failure, peripheral vascular disease, diabetes, depression, and morbid obesity. In addition, 16 at risk for pressure ulcers and had diabetic foot ulcers. R16's physician orders dated 6/11/24 stated, "Wound care: Left Gluteus: Cleanse with wound cleanser. Apply Calmoseptine (ointment). Cover with foam dressing. Every day shift" and "Wound care: Right Gluteus. Cleanse with soap and water. Apply Calmoseptine after peri-care. Every shift". R16's care plan (CP) revised on 5/30/24 stated, "Problem: Resident is currently on Enhanced Barrier Precautions R/T MASD (moisture associated skin damage) on right and left gluteus", and "Problem: Resident is currently on Enhanced Barrier Precautions R/T diabetic ulcer on Left Great toe." During observation and interview on 6/11/24 at 7:12 a.m., R16's door to hallway had an	F 880		

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F 880	Continued From page 76 over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. R16's door and rest of room did not have signage indicating EBP. There was a PPE plastic garbage can with lid on it inside room next to foot of bed. The door was open to the hallway. R16 in electric wheelchair. Two staff members were in the room with a patient lift unit (Hoyer) sling attached to R16 and transfer initiated from wheelchair to bed. Nursing assistant (NA)-D wearing surgical face mask and gloves and no PPE gown. NA-E wearing gloves but no PPE gown. NA-D stated she, "wear [sic] mask sometimes when we go into room. We wear a mask. He [R16] is not on precautions." During observation and interview with registered nurse (RN)-B on 6/11/24 at 7:19 a.m., RN-B entered R16 room with gloves and surgical mask but no PPE gown. RN-B assisted with Hoyer transfer of resident to bed. RN-B stated, "[R16] no longer has a wound. Should not be on EBP now." During observation and interview with NA-C on 6/11/24 at 7:33 a.m., NA-C entered R16's room with a surgical mask on and gloves but no PPE gown. NA-C also assisting NA-E, NA-D, and RN-B with direct hands on care for Hoyer transfer from wheelchair to bed. During interview with director of nursing (DON) who is also the infection control preventionist (IC) on 6/11/24 at 8:59 a.m., IC looked in R16's EMR and stated, "Yes, he has a MASD and should be on EBP. Oh wait, it was resolved last week on wound rounds. The nurse manager probably did not remove all of it [signage and PPE equipment]. She should have after the wound rounds." IC	F 880		

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F 880	Continued From page 77 stated R16's EMR lacked progress notes or wound care notes indicating R16 was to come off of EBP prior to 6/11/24. IC stated staff wound not be aware of any changes or updates unless there was documentation to support it in the EMR and would expect all staff to follow EBP for R16 until the EMR was updated. R93 R93's care plan (CP) dated 4/3/24 state a focus of, "Problem: Resident is currently on Enhanced Barrier Precautions R/T enteral feeding" with "Interventions/Tasks" of, "-Staff to follow Enhanced Barrier Precautions, -Staff to don/doff PPE (personal protective equipment) per enhanced barrier precautions when providing high contact cares". R93's physician orders dated 4/23/24 state, "Resident is currently on Enhanced Barrier Precautions for Enteral Feed every shift". During observation and interview on 6/10/24 at 1:36 p.m., the shared room for R57 and R93's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. Signage posted on the door frame stated EBP expectation for staff who care for R93 to wear PPE gown and gloves when providing direct hands on care such as transferring. No PPE garbage can was observed inside or outside R93's room. NA-B exited room without a PPE gown, asking for licensed practical nurse (LPN)-A for assistance with transferring R93 into bed. LPN-A entered room with PPE gown, gloves, and surgical mask. LPN-A stated, R93 on EBP due to, "He had a wound on the side of his knee." NA-B put on a PPE gown from the door unit and then entered R93 room. Both NA-B	F 880		

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F 880	Continued From page 78 and LPN-A transferred R93 to bed using the Hoyer. After the transfer was completed, LPN-A exited room with her PPE gown, gloves and mask on and walked down the hall towards the nursing station. LPN-A did not wash her hands prior to exiting the room. NA-B removed gown and gloves and placed the used PPE into a plastic garbage can liner and closed it prior to exiting R93's room. NA-B was unaware of PPE garbage can ever being present in R93's room. During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated, "the PPE garbage should always [sic] in the [R93] room due to EBP. It was put in there yesterday after you [surveyor] was in here". LPN-A stated, "I should not have walked out of his room with the gown and gloves on when we were transferring him. I should have removed them in the room and put them in a bag or something and then sanitized my hands before exiting the room [sic] and re-applied the gown and gloves before going back into his room to help [NA-B] with the Hoyer transfer." During interview with IC on 6/11/24 at 8:59 a.m., IC stated, "staff should not be exiting EBP rooms with face mask, gown and gloves on." IC stated expectation of staff to follow EBP signage instructions to don and doff PPE when working with residents that have EBP signage posted on their doors. Facility policy titled Enhanced Barrier Precautions revised 4/1/24, state, "[EBP] refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi-drug resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with	F 880		

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F 880	Continued From page 79	F 880		

wounds or indwelling medical devices)." Further, "Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions" and initiation of EBP for residents with wounds and indwelling medical devices (such as feeding tubes). Also, "Position a trash can inside the resident room for discarding PPE (personal protective equipment) after removal, prior to exit of the room". High -contact resident care activities include, "Dressing, Bathing, Transferring, Providing hygiene, Changing linens, Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and Wound care: any skin opening requiring a dressing."

16

STAFF FEEDING MULTIPLE RESIDENTS WITHOUT HAND HYGIENE

During observation on 6/12/24 at 8:37 a.m., certified nursing assistant (CNA)-O was passing out breakfast trays to residents in the third-floor dining room. CNA-O then sat down to assist R2 with eating without performing hand hygiene.

During observation on 6/12/24 at 8:45 a.m., CNA-O stopped assisting R2 with eating her breakfast and started assisting R23 with her breakfast without performing hang hygiene in between residents.

During observation on 6/12/24 at 8:52 a.m., CNA-J was sitting between R14 and R55, assisting them both with eating their breakfast, switching between each residents' utensils with the same hand. CNA-J did not perform hand hygiene in between. R55 was noted to have a

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F 880	Continued From page 80 wet, non-productive cough. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated the expectation was for the CNAs to perform hand hygiene before assisting residents with eating. During an interview on 6/13/24 at 1:51 p.m., the infection preventionist and director of nursing (DON) stated hand hygiene was expected before and after assisting residents with eating and in between residents if the same hand is being used to assist. DINING: R35's annual Minimum Data Set (MDS) dated 5/8/24, indicated R35 had intact cognition and was diagnosed with heart failure, kidney failure, diabetes, and respiratory failure. R53's quarterly MDS dated 2/7/24, indicated R53 had moderately impaired cognition and was diagnosed with diabetes, a stroke, and malnutrition. The MDS indicated that R53 required a feeding tube and a mechanically altered diet. R53's order summary report dated 4/23/24, indicated R53 was on enhanced barrier precautions "for enteral feed". R58's quarterly MDS dated 3/7/24, indicated R58 had intact cognition and was diagnosed with heart failure, diabetes, and asthma.	F 880		

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F 880	Continued From page 81 R59's quarterly MDS dated 3/26/24, indicated R59 had intact cognition and was diagnosed with anemia, depression, and anxiety. The MDS indicated the presence of a surgical wound. R59's order summary report dated 6/10/24, indicated R59 had a wound and was on enhanced barrier precautions. R64's quarterly MDS dated 5/1/24, indicated R64 had intact cognition and was diagnosed with anemia and malnutrition. R67's quarterly MDS dated 3/13/24, indicated R67 had intact cognition and was diagnosed with a leg fracture. R112's quarterly MDS dated 3/28/24, indicated R112 had intact cognition and was diagnosed with kidney disease, diabetes, and hypertension. During an observation on 6/10/24 at 5:54 p.m., nursing assistants (NA)-H and NA-I were observed pushing a tall cart containing meal trays down the hallway toward resident rooms. NA-H was observed to enter R53's room with a meal tray in hand. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. A sign indicating R53 was on enhanced barrier precautions and "everyone must: clean their hands, including before entering and when leaving the room" was observed on the door. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R58's room tray from the cart and enter R58's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table,	F 880		

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F 880	Continued From page 82 and exiting the room. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R35's room tray from the cart and enter R35's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. No hand hygiene upon entering or exiting the room was observed. During an observation on 6/10/24 at 6:00 p.m., NA-I was observed to enter R64's room with a meal tray, move personal items on the table, and exit the room. No hand hygiene was observed. NA-I was then observed to grab R67's tray, enter the resident's room, set the tray on the table, and exit. No hand hygiene was observed. NA-I was observed to grab R59's food tray, enter the resident's room, move items on the resident's table, and remove used-looking cup. A sign indicating R59 was on enhanced barrier precautions and "everyone must: clean their hands, including before entering and when leaving the room" was observed on the door. NA-I exited the room, and no hand hygiene was observed. NA-I was observed to grab the meal tray for R112 and enter the resident's room. During an interview on 6/10/24 at 6:03 p.m. with NA-H and NA-I, NA-H stated they were taught to complete hand hygiene before starting to pass meal trays and when they are completed with all of the trays but not between individual rooms and NA-I agreed. NA-H and NA-I acknowledged they had not completed hand hygiene before entering and exiting the rooms above including the residents on enhanced barrier precautions. During an interview on 6/13/24 at 1:45 p.m., the	F 880		

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F 880	Continued From page 83	F 880		

director of nursing (DON) stated she expected the NAs to complete hand hygiene before and after a resident room while passing room trays to prevent the possible spread of infection.

The CDC article, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, indicates hand hygiene is an important part of stopping the spread of "deadly germs" to residents including those resistant to antibiotics. The article indicates hand hygiene should be completed after touching a resident or their surroundings, after contact with a contaminated surface, and immediately before touching a resident.

The facility's Handwashing policy dated 2/24, indicated hand washing should be performed by all employees between tasks and procedures to prevent cross-contamination.

ASSISTING MULTIPLE RESIDENTS WITH EATING WITHOUT PERFORMING HAND HYGIENE

On 6/12/24 at 8:19 a.m., on 3rd floor dining room in men's care memory unit, it was observed staff assisting resident with breakfast. Nursing assistant (NA)-B alternating between feeding R80, R3 and R33. NA-B was observed using primarily one hand to assist the residents to eat.

On 6/12/24 at 10:57 a.m., NA-B verified they were assisting 3 residents at the same time during breakfast today and verified the residents listed above. NA-B stated they wiped down the residents' hands prior to the meal. NA-B stated they did hand hygiene prior to starting to assist the residents with breakfast. NA-B verified they

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F 880	Continued From page 84 did not perform hand hygiene in between helping residents and used the same hand to feed all 3 residents. NA-B verified residents listed above are dependent on staff for assistance with meals. On 6/13/24 at 11:12 a.m., director of nursing (DON) stated "it's a standard thing" to perform hand hygiene while assisting residents with meals and between residents. DON stated it is important to ensure cross contamination doesn't occur and "they need to clean their hands." F880 - WASH MACHINE During observation of laundry room tour on 6/12/24 at 9:08 a.m., a one-page document was observed hanging on a bulletin board by the entryway door, titled "Any Shift Laundry Routine." The document provided guidelines on what should be done throughout shift indicating the start and end of shift. The start of shift indicated "Load Dryers". At the end of shift, it indicated "Load Washers ....". On 6/12/24 at 9:10 a.m., laundry aide (LA)-A and regional district manager (RDM) present during laundry room tour. LA-A verified they worked full-time in laundry services and were familiar with the job. LA-A and RDM verified the document titled "Any shift laundry routine" was up-to date with expectations. LA-A verified that prior to the end of their shift, they start with wash machines with a load of laundry. LA-A verified the laundry sits in the wash machine through the evening shift and night shift until the next day when staff from the laundry department come in to start their shift. LA-A verified when they start their shift in the morning, they take the laundry from the wash machine, that was started at the end of their shift	F 880		

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F 880	Continued From page 85 the day prior and put it in the dry machine. On 6/12/24 at 9:13 a.m., RDM verified that she oversees the department and was covering as the manager was out. When asked about leaving laundry in the wash machine overnight, RDM stated, "We are not supposed to do that anymore, we were told that last year." RDM stated she didn't realize it hadn't been updated and would get it corrected. RDM stated leaving wash in the wash machine overnight is of concern "because it could grow bacteria and things on it." On 6/12/24 at 9:38 a.m., administrator stated laundry shouldn't be wet in the wash machine overnight due to "potential bacteria growth". 6/12/24 at 1:43 p.m., RDM stated staff working were provided education regarding not leaving laundry in wash machines overnight, an updated "laundry routine" was hung. RDM stated the remaining laundry staff, and the manager will be in-services upon their return. A facility policy on wet linens/wash machine relating to infection control was requested and not received.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		7/17/24

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F 883	Continued From page 86 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		

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F 883	Continued From page 87 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the current standards of vaccinations regarding pneumonia for 1 of 5 residents (R17) over 65 years old whose vaccinations histories were reviewed. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R17's facility Immunization Record, print date 6/13/24, indicated he was 82 years old. The record indicated he received PPSV23 on 1/31/2013 followed by the PCV-13 on 10/4/2016. The immunization record lacked evidence of other pneumococcal immunizations offered, refused, or completed. R17's Care Conference Form, dated 5/8/24,	F 883	F883 1.R17 PCV20 vaccine was offered. R17 is not affected. 2. Residents with outdated pneumococcal immunization have the potential to be affected. Like residents will be reviewed to ensure documentation is completed in the immunization record of offered, refused or completed pneumococcal vaccination. 3.Licensed nurses will be educated about the up-to-date pneumococcal vaccination. Licensed nurse will offer missing vaccine upon admission and nurse leader will review vaccination during resident ARD. Licensed nurses and nurse leaders will be educated on documentation of offering, refusing, and completed vaccines in the immunization record. 4.Audits will be completed of residents on admission and quarterly of pneumococcal vaccines to ensure documentation is completed in the immunization record indicating offered, refused or completed vaccines and PCV20 is being offered if appropriate. Five audits per week x 4 weeks then once weekly x4 weeks. The results will then be shared with the facility QAPI Committee for input on the need to	

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F 883	Continued From page 88 summarizes a quarterly care conference. The form has a section to address immunizations: Section H: Immunizations (i.e., pneumococcal, influenza, Covid series) was not completed. The section lacked evidence of completion. On 6/13/2024 at 10:14 a.m., director of nursing verified that she is the infection preventionist for the facility. She verified that she oversees the immunizations. DON indicated the nurse managers review and determine what immunizations residents need and they will work with their power of attorney (POA) or guardian if they are not able to make their own decisions. DON verified R17's pneumococcal immunizations as listed above and would be eligible for the PCV20. DON stated she followed up with the nurse manager on the floor who has called R17's guardian, received approval for administration of PCV20. DON verified R17's guardian was updated regarding eligibility of immunization on 6/13/24, stated "the nurse manager lost her list of who needs it but did call now." DON indicated it is important to offer residents immunizations they are eligible for. A facility policy titled "Pneumococcal Policy", dated 2/24, was provided. Policy indicated to offer all residents the pneumococcal vaccines to aid in the prevention of pneumococcal/pneumonia infections by following the Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control (CDC) and/or the state Department of Health.	F 883	increase, decrease, or discontinue the audits. 5. Audits will be completed by DON or designee.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions	F 921		7/17/24

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F 921	Continued From page 89 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 closet doors in disrepair were reported and acted upon in a timely manner to promote a safe, homelike environment for 1 of 1 resident (R92) reviewed whose closet door was broken with exposed nails present. Findings include: A Vulnerable Adult Maltreatment Report, dated 7/2023, identified a general concern about the care center which included, " ... [it] needs major repairs and there are multiple things that are broken." R92's quarterly Minimum Data Set (MDS)assessment, dated 3/21/24, identified R92 had intact cognition and demonstrated no delusional thinking. On 6/10/24 at 1:46 p.m., R92 was observed lying in bed while in his room. The room had an off-white colored closet with double doors which opened towards the foot of R92's bed. However, the closet door was in disrepair with the door and attached frame being pulled away from the wall several inches exposing multiple construction nails with the bevel-end open to the outside (i.e., room). The door was loose to touch and the closet' interior was visible through the exposed gap between the frame and wall. The closet had visible clothing and CPAP (low pressure air machine used to help breathing) supplies inside.	F 921	F921 1.R92 was not affected by this practice. As soon as the Maintenance Director was aware of the door needing repair, he fixed it immediately. 2.All other residents could be affected by this practice. Closet doors will be reviewed, and work order entered if warranted. Education will be completed with all staff to enter work orders when they see something is broken and needs to be repaired. 3.Five audits will be completed weekly for 4 weeks and once weekly for 4 weeks to ensure work orders were put in. 4.Audits will be completed by NHA or designee. Audits will be brought to QAPI for review by NHA or designee.	

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	245148	A. BUILDING _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

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F 921	Continued From page 90 R92 was interviewed and stated the closet was "broken" and had been for "a couple weeks." R92 stated he had asked staff to complete a 'work-order' for it to get it fixed, however, no action had been taken on it yet. R92 stated, "I don't think anybody put in a work order [despite being asked]." R92 stated he wanted it fixed and was fearful the door would eventually fall off and onto his bed with him in it. Two days later, on 6/12/24 at 9:02 a.m., the closet door was again observed and remain in disrepair with exposed nails. When interviewed on 6/12/24 at 9:41 a.m., nursing assistant (NA)-D stated R92 needed "100% total" help with cares and was mostly bed-bound. NA-D observed R92's closet door and stated aloud, "It's coming apart!" NA-D stated they were unaware the closet was in disrepair and attempted to move the closet door when it then fell completely off the wall. NA-D stated, "It came out." R92 was present in his bed and again reiterated it had been in such condition "for sure, over a week now." NA-D stated they were unsure if maintenance was aware of it or not and expressed they would get it entered "in TELS [software]" right away to be addressed. On 6/12/24 at 12:33 p.m., the director of maintenance (DOM) was interviewed. DOM explained if staff notice items in disrepair then a TELS work-order should be place so the maintenance staff can be updated about it. DOM stated they had just been made aware of R92's closet door being in disrepair (during the survey) as "nobody put it on there [TELS]." DOM verified none of the staff had completed a TELS and, as a result, nobody from maintenance was aware it was in disrepair adding the closet door "was	F 921		

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F 921	Continued From page 91 pulled from the frame itself" and needed multiple staff members to help repair it just prior. DOM stated R92 was mostly bed-bound so it was likely someone else, likely staff, who broke the door adding, "It had to be somebody with quite some force." DOM reiterated it should have been reported to them for repair adding, "I don't know how somebody [would] not notice that." DOM added, "It could fall on somebody," and, "It's a safety thing." A Work Order #16293, dated 6/12/24, identified R92's room along with a heading, "Cloet [sic] door broken." A timeline was present which identified the tracking through the TELS system; this outlined it had been created on 6/12/24. There was no further evidence provided to demonstrate the broken closet door had been notified or addressed prior to 6/12/24. A facility' policy on maintenance requests or repairs was not received.	F 921		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/10/24 to 6/13/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, a complaint investigation was completed. Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please	2 000		

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2 000	Continued From page 1 indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H51484388C (MN95247); non-compliance cited at 1665. H51484386C (MN96373) H51484384C (MN97002) H51484382C (MN98204) H51484383C (MN98568) H51484385C (MN98693) H51484387C (MN98881) H51484389C (MN99241) H51484540C (MN103985); non-compliance cited at F600. MDH is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulatio	2 000		

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2 000	Continued From page 2 n/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure routine personal hygiene assistance was provided to 1 of 1 residents (R56) reviewed for ADLs.	2 850	Corrected	7/17/24

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2 850	Continued From page 3 Finding include: R56's quarterly MDS assessment, dated 4/4/24, indicated R56 had intact cognition. MDS indicated R56 required partial assistance for shaving. MDS indicated no behaviors or rejection of care. R56's care plan, identified R56 needed "assist with facial shaving- weekly on bath day as needed." R56's nursing assistant care sheet identified R56 was "assist of 1 for all ADLs-make sure she is completing hygiene daily. Shave facial hair as needed on shower day.". On 6/10/24 at 1:21 p.m., R56 was observed standing in her room and had a facial beard, approximately half inch long. R56 stated, "I would feel better if it was gone .... I would like to try something, maybe an electric razor." R56 indicated "they gave me a razor once, but it left it rough," and further expressed that she did not like the facial hair, and would like it gone. On 6/11/24 at 1:15 p.m., R56 was observed in her room. R56 stated she had just taken a shower and stated, "they helped me shave". R56 further expressed, "I feel much better". R56 stated "they don't always do that but did today ... ...used a razor that just rolled over and it worked pretty good .... I feel a lot better." R56 stated it's "been a while... I don't remember the last time they asked me about shaving." On 6/13/24 at 9:37 a.m., licensed practical nurse (LPN)-E stated R56 was assist of 1 with ADLs, needs set up, and needs staff assistance to shave facial hair once a week on shower days as needed. LPN-E verified this on the nursing	2 850		

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2 850	Continued From page 4 assistance sheet. On 6/13/24 at 9:42 a.m., nursing assistant (NA)-J verified they are familiar with R56. NA-J stated R56 needs "set up" for most ADL's, further clarifying staff set up her clothing and she can put them on herself. NA-J stated R56 needs set up and stand by assist for showers and R56's "facial hair is done by staff on shower days." NA-J stated it is important to keep R56 facial hair shaved "for dignity purposes." On 6/13/24 at 11:15 a.m., director of nursing stated getting rid of facial hair for women is a dignity issue, want to make sure that residents are presentable and feel good. A facility policy titled "Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 5/9/24, was provided. The document indicated it will "create and sustain an environment that humanizes and individualizes each resident's quality of life." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet	2 860		7/17/24

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2 860	Continued From page 5 Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure routine personal hygiene assistance was provided to 1 of 1 residents (R28) reviewed for ADLs. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 5/16/24 identified admission to facility on 1/5/12 and intact cognition. During observation on 6/10/24 at 2:13 p.m., R28 laying in bed, dressed and had black matter under her fingernails. During observation and interview with R28 on 6/11/24 at 2:27 p.m., R28 laying in bed, dressed and had black matter under her fingernails. R28 stated, "No, no one asks me if they can cleanout my nails. They can be gross if not soaked and taken care of. The aide [nursing assistant] should be asking me at least." During interview with registered nurse (RN)-D on 6/11/24 at 2:27 p.m., RN-D stated she had worked full time at the facility for "five years" and normally worked on the unit with R28. RN-D stated, "nurses are responsible for making sure the nails are cleaned and washed up for the day."	2 860	Corrected.	

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2 860	Continued From page 6 RN-D looked at R28's nails and stated, "they should be cleaned and trimmed." During interview with RN-C on 6/11/24 at 2:48 p.m., stated she was the nurse manager of the unit R28 resides on. RN-C stated, nursing assistants should take care of nail care right away. During interview with RN-C on 6/12/24 at 8:10 a.m., RN-C said she looked at R28's nails yesterday,they are taken care of now and verified R28 had black stuff under them which needed to be cleaned. During interview with director of nursing (DON) on 6/13/24 at 8:28 a.m., DON stated nail care is to be done, "weekly" and as needed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nailcare for dependent residents. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities	2 890		7/17/24

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2 890	Continued From page 7 through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a 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 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the failed to provide services to maintain and/or prevent loss of range of motion and contracture care for 1 of 1 residents (R93) reviewed for limited range of motion. Further, the facility failed to maintain a resident's walking program to prevent any loss of independence, strength or range of motion for 1 of 1 resident (R108) reviewed. Findings include: R93's quarterly Minimum Data Set (MDS) assessment dated 3/28/24 included severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's physician orders (PO) dated 2/1/23 indicates, "Tx [treatment] to R[right] hand to protect from skin breakdown: Wash hand with	2 890	corrected.	

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2 890	Continued From page 8 warm soapy water, ensure skin is dried completely, weave gauze between fingers, place ABD (abdominal pads or ABD dressings for large or draining wounds) to palm of hand and wrap with kerlix. Change QOD [every other day]. Update manager and MD/NP [medical doctor/nurse practitioner] if open areas appear. Every evening shift every other day". R93's care plan (CP) goal dated 4/8/22 included, history of open area to palm of hand, Self care deficit related to impaired mobility, and contractures of URE (upper right extremity) and associated interventions of Follow OT [occupational therapy] instructions and R93 required extensive assist of 1 with personal hygiene and dressing. During observation on 6/10/24 at 1:36 p.m., R93 sitting in wheelchair in room with right hand contracted and pulled into the torso with left hand supporting the right hand. Right hand had rolled up washcloth in it. During observation on 6/10/24 at 5:40 p.m., R93 in bed with rolled up washcloth in his hand. R93's clothes closet, which was across from R93's bed had printed PROM exercises taped to the closet door. PROM exercise instructions, dated 4/15/22 showed diagrams and explanations included, "Ankle Rotation, Knee and Hip Flexion and Extension, Toe Flexion and Extension, Ankle Flexion and Extension, Hip Abduction and Adduction (out and in). Exercises should be done 2-3 times per day with 10-20 reps." The form had highlighted area stated, "Do all movements slowly and smoothly. Don't force the body to move beyond its comfortable range." R93's nursing assistant care sheet updated	2 890		

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2 890	Continued From page 9 6/6/24, failed to include passive range of motion exercises to be provided to resident and what cares were needed for the right contracted hand. During interview with nursing assistant (NA)-B on 6/10/24 at 1:36 p.m., NA-B stated he was full time employee and worked over fifteen years at facility and familiar with R93. NA-B stated, "I don't know anything about helping with R93's exercises. It should be on the care sheet and care plan for me to do. I don't' know anything about a splint for R93's hand . NA-B stated he was unaware of why there was a rolled up washcloth in R93's right hand. During observation on 6/11/24 at 8:24 a.m., R93 in bed wearing hospital gown. Right hand with rolled up washcloth in it. During interview with licensed practical nurse (LPN)-A on 6/11/24 at 8:38 a.m., LPN-A stated she was familiar with R93 and was unaware why the washcloth was in his hand. LPN-A verified they were not in the care plan or orders and should be. During interview with NA-F on 6/12/24 at 7:45 a.m., NA-F verified being familiar with R93's wing and PROM was to be completed daily. NA-F was not aware of the washcloth or who placed it. During observation on 6/12/24 at 8:16 a.m., R93 laying in bed wearing hospital gown. Right hand with rolled up washcloth in it. During interview with occupational therapist (OT) on 6/12/24 at 9:45 a.m., OT stated PROM exercises are recommended for all residents with hand and limb contractures to prevent decline in mobility. OT stated therapy orders and	2 890		

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2 890	Continued From page 10 recommendations are provided to the nurse manager on the unit once each residents is assessed on admission and as needed per physician order. The exercises are then posted with instructions to post on the closet door of each resident for staff to refer to when performing the daily exercises. Then, the nurse manager will update nursing assistant care sheets and the resident care plan to implement the PROM and other recommendations. OT looked in R93's EMR and stated, "[I] don't know anything about a washcloth rolled up in [R93's] hand." Also, OT stated R93s EMR failed to identify what PROM exercises were recommended. During interview with the director of therapy (DT) on 6/12/24 at 10:17 a.m., DT stated all residents are seen for therapy evaluations upon admission. "If [they have] contractures like R93, we find out if they had a splint [prior to admission] and assess them for it". DT stated R93 "is non verbal so they [therapy] rely on family and nurses to determine if R93 tolerates it". DT looked in R93's EMR and stated, "I would recommend a palm guard or rolled up washcloth [to R93's right hand]. I would expect that to be in his [R93's] care plan [and care sheets] to let staff know what to do with his hand". DT stated R93's care plan, orders, and care sheets did not have interventions to perform PROM or apply a washcloth or splint to R93's right hand. DT stated, "I don't see it and it should be [in R93's EMR]." During interview with registered nurse (RN)-D on 6/12/24 at 11:22 a.m., RN-D stated, "yes, he [R93} has a hand splint. All of this [including PROM exercises] should be in the care plan [sic] for staff to know what to do." RN-D looked in R93's EMR and stated, "it should be in [R93's] care plan. I don't see anything in his chart to tell	2 890		

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2 890	Continued From page 11 staff about his hand splint [and PROM]". During interview with family member (FM)-A on 6/12/24 at 11:15 a.m., FM-A stated he was R93's primary emergency contact, "[R93] had a splint to right hand. He had one but I don't know if he still has one. I haven't seen it for along time. In fact, I don't know if he still has it." FM-A stated facility had not communicated with him "in the past year" about the contracture to R93's right hand. Also, FM-A stated he was unaware of R93 receiving any form of PROM exercises, and "he should". During interview with director of nursing (DON) on 6/13/24 at 2:49 a.m., DON stated R93's EMR failed to address PROM and splint use or palm guard. DON stated, "these should be in there for staff to know what to do and when." R93 paper form received by DT to surveyor and downloaded on 6/13/24 at 11:26 a.m., titled Splint and ROM Implementation Timeline indicate occupational therapy recommended on 4/19/22, "PROM established and paper copy with instructions provided to nursing-splinting not indicated due to pts noncompliance with splint assessment and trials". Form also indicated on 4/15/22 physical therapy established a PROM for R93 and, "paper copy with instructions provided to nursing". R108 R108's quarterly Minimum Data Sat (MDS) assessment, dated 5/14/24, indicated R108 had severe cognitive impairment, had no impairment to her upper or lower extremities and required partial to moderate assistance with activities of daily living (ADLs) including ambulation.	2 890		

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2 890	Continued From page 12 R108's physician order, dated 4/25/24, directed staff to walk R108 three times a day to meals using a four wheeled walker. R108's care plan, dated 6/5/24, indicated R108 should be walked to meals three times a day using a four wheeled walker per therapy. R108's care sheet, printed 6/12/24, indicated the nursing assistants were to walk R108 three times a day to meals using a four wheeled walker. R108's Tasks documentation for the nursing assistance for the month of June indicated R108 walking in the unit hallway was documented as "not applicable." During observation on 6/12/24 at 7:10 a.m., R108 was sitting out in the main dining area in her wheelchair, waiting for breakfast. During an interview on 6/12/24 at 7:15 a.m., nursing assistance (NA)-J stated the nursing assistants use the care sheets to know what cares to provide the residents. NA-J confirmed R108 can walk but was wheeled out in her wheelchair to the breakfast table after morning cares. During observation on 6/12/24 at 9:16 a.m., R108 was wheeled away from the dining room table and wheeled into her room. During an interview on 6/12/24 at 2:04 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated the expectation was for the nursing assistants to follow the care sheets and walk R108 to meals. LPN-D confirmed the aides were not walking R108 to meals stating, "they need to be better at that" to help R108 maintain	2 890		

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2 890	Continued From page 13 her mobility. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) confirmed it would be expected that the nursing assistants are following the care sheets and walking R108 to meals every day. A facility polity titled Activities of Daily Living (ADLs)/Maintain Abilities Policy updated 5/9/24, state "the facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		7/17/24

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21375	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to utilize infection control practices while administering medications through gastrostomy tube for 1 of 1 residents (R93) observed for medication administration, utilize infection control practices while delivering meal trays to resident rooms for 7 of 7 residents (R35, R53, R58, R59, R64, R67, R112) observed for dining, while assisting multiple residents to eat at once for 7 of 33 residents (R2, R3, R14,R23, R33, R55, R80) observed for dining. In addition, the facility failed to implement and maintain enhanced barrier precautions (EBP) for 2 of 2 resident (R16, R93) reviewed for transmission based precautions. Furthermore, the facility failed to mitigate transmission of potential infections in relation to laundering of linens and personal items. Findings include: Med Admin R93 R93's quarterly Minimum Data Set (MDS) dated 3/28/24 state admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's physician orders (PO) dated 4/8/22 direct staff to, "Crush each medication in 15ml of warm purified or sterile water and administer each separately using gravity." R93's PO dated 4/22/24 stated, "Before administering medication, stop feeding for 30 minutes and flush the tube with at	21375	Corrected.	

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21375	Continued From page 15 least 15 milliliters (mL) sterile water." During observation on 6/12/24 at 8:16 a.m., licensed practical nurse (LPN)-A entered R93's room with four medication cups of crushed medications and placed them on his bedside table. LPN-A then obtained the sixty cubic centimeter (cc) piston syringe from his bedside table and added water from a plastic cylinder into each medication cup. LPN-A then paused R93's enteral feeding that was running and removed his abdominal binder to access his GT. LPN-A then auscultated and assessed R93's GT for placement by connecting piston syringe with water in it to R93's GT port and injecting and withdrawing water. LPN-A then disconnected piston syringe from GT port and bent the tubing connected to the resident with her left hand while reaching over to the bedside table and aspirating (withdrawing) medication mixture from one medication cup with her right hand. LPN-A then connected the medication filled piston syringe to the GT port and unbent the GT that was attached to R93. LPN-A then administered medication and bent the GT with left hand and reached over to the bedside table to withdraw another medication. During this process LPN-A allowed the tip of the piston syringe to touch R93's hospital gown several times and used the piston syringe to add more water to the next medication cup. LPN-A then withdrew it into the piston syringe and repeated process until all four medications were administered. During administration LPN-A allowed the tip of the piston syringe to touch R93's hospital gown again before adding more water to the piston syringe and flushing the GT port to end the process. LPN-A re-connected enteral feeding tube and re-applied R93's abdominal binder.	21375		

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21375	Continued From page 16 During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated she had not turned off R93's enteral feeding for thirty minutes prior to administering his medications per PO and, "I should have". Also, "the piston syringe should never touch the resident gown when administering GT meds. Contamination is a concern." During interview with director of nursing (DON) on 6/11/24 at 9:08 a.m., DON stated, "GT feeding tip of piston syringe should not touch gown of resident due to risk of contamination. Staff should [have] replaced it and [sic] get a new one if the end touches anything like the gown of a resident." Facility policy titled Administering Medications through an Enteral Tube updated 3/23/23, "stop the feeding at least 30 minutes prior to medication administration and restart at least 30 minutes after medication administration." And, "Place the end of the tubing on a clean gauze pad positioned on the abdomen or chest of the resident". EBP R16 R16's quarterly MDS dated 4/16/24, stated admission to facility on 12/14/23, had intact cognition, and diagnoses of coronary artery disease (CAD), heart failure, peripheral vascular disease, diabetes, depression, and morbid obesity. In addition, 16 at risk for pressure ulcers and had diabetic foot ulcers. R16's physician orders dated 6/11/24 stated, "Wound care: Left Gluteus: Cleanse with wound cleanser. Apply Calmoseptine (ointment). Cover with foam dressing. Every day shift" and "Wound care: Right Gluteus. Cleanse with soap and	21375		

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21375	Continued From page 17 water. Apply Calmoseptine after peri-care. Every shift". R16's care plan (CP) revised on 5/30/24 stated, "Problem: Resident is currently on Enhanced Barrier Precautions R/T MASD (moisture associated skin damage) on right and left gluteus", and "Problem: Resident is currently on Enhanced Barrier Precautions R/T diabetic ulcer on Left Great toe." During observation and interview on 6/11/24 at 7:12 a.m., R16's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. R16's door and rest of room did not have signage indicating EBP. There was a PPE plastic garbage can with lid on it inside room next to foot of bed. The door was open to the hallway. R16 in electric wheelchair. Two staff members were in the room with a patient lift unit (Hoyer) sling attached to R16 and transfer initiated from wheelchair to bed. Nursing assistant (NA)-D wearing surgical face mask and gloves and no PPE gown. NA-E wearing gloves but no PPE gown. NA-D stated she, "wear [sic] mask sometimes when we go into room. We wear a mask. He [R16] is not on precautions." During observation and interview with registered nurse (RN)-B on 6/11/24 at 7:19 a.m., RN-B entered R16 room with gloves and surgical mask but no PPE gown. RN-B assisted with Hoyer transfer of resident to bed. RN-B stated, "[R16] no longer has a wound. Should not be on EBP now." During observation and interview with NA-C on 6/11/24 at 7:33 a.m., NA-C entered R16's room with a surgical mask on and gloves but no PPE	21375		

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21375	Continued From page 18 gown. NA-C also assisting NA-E, NA-D, and RN-B with direct hands on care for Hoyer transfer from wheelchair to bed. During interview with director of nursing (DON) who is also the infection control preventionist (IC) on 6/11/24 at 8:59 a.m., IC looked in R16's EMR and stated, "Yes, he has a MASD and should be on EBP. Oh wait, it was resolved last week on wound rounds. The nurse manager probably did not remove all of it [signage and PPE equipment]. She should have after the wound rounds." IC stated R16's EMR lacked progress notes or wound care notes indicating R16 was to come off of EBP prior to 6/11/24. IC stated staff wound not be aware of any changes or updates unless there was documentation to support it in the EMR and would expect all staff to follow EBP for R16 until the EMR was updated. R93 R93's care plan (CP) dated 4/3/24 state a focus of, "Problem: Resident is currently on Enhanced Barrier Precautions R/T enteral feeding" with "Interventions/Tasks" of, "-Staff to follow Enhanced Barrier Precautions, -Staff to don/doff PPE (personal protective equipment) per enhanced barrier precautions when providing high contact cares". R93's physician orders dated 4/23/24 state, "Resident is currently on Enhanced Barrier Precautions for Enteral Feed every shift". During observation and interview on 6/10/24 at 1:36 p.m., the shared room for R57 and R93's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. Signage posted on the door frame stated EBP expectation for staff who care	21375		

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21375	Continued From page 19 for R93 to wear PPE gown and gloves when providing direct hands on care such as transferring. No PPE garbage can was observed inside or outside R93's room. NA-B exited room without a PPE gown, asking for licensed practical nurse (LPN)-A for assistance with transferring R93 into bed. LPN-A entered room with PPE gown, gloves, and surgical mask. LPN-A stated, R93 on EBP due to, "He had a wound on the side of his knee." NA-B put on a PPE gown from the door unit and then entered R93 room. Both NA-B and LPN-A transferred R93 to bed using the Hoyer. After the transfer was completed, LPN-A exited room with her PPE gown, gloves and mask on and walked down the hall towards the nursing station. LPN-A did not wash her hands prior to exiting the room. NA-B removed gown and gloves and placed the used PPE into a plastic garbage can liner and closed it prior to exiting R93's room. NA-B was unaware of PPE garbage can ever being present in R93's room. During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated, "the PPE garbage should always [sic] in the [R93] room due to EBP. It was put in there yesterday after you [surveyor] was in here". LPN-A stated, "I should not have walked out of his room with the gown and gloves on when we were transferring him. I should have removed them in the room and put them in a bag or something and then sanitized my hands before exiting the room [sic] and re-applied the gown and gloves before going back into his room to help [NA-B] with the Hoyer transfer." During interview with IC on 6/11/24 at 8:59 a.m., IC stated, "staff should not be exiting EBP rooms with face mask, gown and gloves on." IC stated expectation of staff to follow EBP signage instructions to don and doff PPE when working	21375		

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21375	Continued From page 20 with residents that have EBP signage posted on their doors. Facility policy titled Enhanced Barrier Precautions revised 4/1/24, state, "[EBP] refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi-drug resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)." Further, "Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions" and initiation of EBP for residents with wounds and indwelling medical devices (such as feeding tubes). Also, "Position a trash can inside the resident room for discarding PPE (personal protective equipment) after removal, prior to exit of the room". High -contact resident care activities include, "Dressing, Bathing, Transferring, Providing hygiene, Changing linens, Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and Wound care: any skin opening requiring a dressing." DINING/ HAND HYGIENE: During observation on 6/12/24 at 8:37 a.m., certified nursing assistant (CNA)-O was passing out breakfast trays to residents in the third-floor dining room. CNA-O then sat down to assist R2 with eating without performing hand hygiene. During observation on 6/12/24 at 8:45 a.m., CNA-O stopped assisting R2 with eating her breakfast and started assisting R23 with her breakfast without performing hang hygiene in between residents.	21375		

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21375	Continued From page 21 During observation on 6/12/24 at 8:52 a.m., CNA-J was sitting between R14 and R55, assisting them both with eating their breakfast, switching between each residents' utensils with the same hand. CNA-J did not perform hand hygiene in between. R55 was noted to have a wet, non-productive cough. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated the expectation was for the CNAs to perform hand hygiene before assisting residents with eating. During an interview on 6/13/24 at 1:51 p.m., the infection preventionist and director of nursing (DON) stated hand hygiene was expected before and after assisting residents with eating and in between residents if the same hand is being used to assist. R35's annual Minimum Data Set (MDS) dated 5/8/24, indicated R35 had intact cognition and was diagnosed with heart failure, kidney failure, diabetes, and respiratory failure. R53's quarterly MDS dated 2/7/24, indicated R53 had moderately impaired cognition and was diagnosed with diabetes, a stroke, and malnutrition. The MDS indicated that R53 required a feeding tube and a mechanically altered diet. R53's order summary report dated 4/23/24, indicated R53 was on enhanced barrier precautions "for enteral feed". R58's quarterly MDS dated 3/7/24, indicated R58 had intact cognition and was diagnosed with heart failure, diabetes, and asthma.	21375		

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21375	Continued From page 22 R59's quarterly MDS dated 3/26/24, indicated R59 had intact cognition and was diagnosed with anemia, depression, and anxiety. The MDS indicated the presence of a surgical wound. R59's order summary report dated 6/10/24, indicated R59 had a wound and was on enhanced barrier precautions. R64's quarterly MDS dated 5/1/24, indicated R64 had intact cognition and was diagnosed with anemia and malnutrition. R67's quarterly MDS dated 3/13/24, indicated R67 had intact cognition and was diagnosed with a leg fracture. R112's quarterly MDS dated 3/28/24, indicated R112 had intact cognition and was diagnosed with kidney disease, diabetes, and hypertension. During an observation on 6/10/24 at 5:54 p.m., nursing assistants (NA)-H and NA-I were observed pushing a tall cart containing meal trays down the hallway toward resident rooms. NA-H was observed to enter R53's room with a meal tray in hand. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. A sign indicating R53 was on enhanced barrier precautions and "everyone must: clean their hands, including before entering and when leaving the room" was observed on the door. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R58's room tray from the cart and enter R58's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table,	21375		

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21375	Continued From page 23 and exiting the room. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R35's room tray from the cart and enter R35's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. No hand hygiene upon entering or exiting the room was observed. During an observation on 6/10/24 at 6:00 p.m., NA-I was observed to enter R64's room with a meal tray, move personal items on the table, and exit the room. No hand hygiene was observed. NA-I was then observed to grab R67's tray, enter the resident's room, set the tray on the table, and exit. No hand hygiene was observed. NA-I was observed to grab R59's food tray, enter the resident's room, move items on the resident's table, and remove used-looking cup. A sign indicating R59 was on enhanced barrier precautions and "everyone must: clean their hands, including before entering and when leaving the room" was observed on the door. NA-I exited the room, and no hand hygiene was observed. NA-I was observed to grab the meal tray for R112 and enter the resident's room. During an interview on 6/10/24 at 6:03 p.m. with NA-H and NA-I, NA-H stated they were taught to complete hand hygiene before starting to pass meal trays and when they are completed with all of the trays but not between individual rooms and NA-I agreed. NA-H and NA-I acknowledged they had not completed hand hygiene before entering and exiting the rooms above including the residents on enhanced barrier precautions. During an interview on 6/13/24 at 1:45 p.m., the director of nursing (DON) stated she expected	21375		

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21375	Continued From page 24 the NAs to complete hand hygiene before and after a resident room while passing room trays to prevent the possible spread of infection. On 6/12/24 at 8:19 a.m., on 3rd floor dining room in men's care memory unit, it was observed staff assisting resident with breakfast. Nursing assistant (NA)-B alternating between feeding R80, R3 and R33. NA-B was observed using primarily one hand to assist the residents to eat. On 6/12/24 at 10:57 a.m., NA-B verified they were assisting 3 residents at the same time during breakfast today and verified the residents listed above. NA-B stated they wiped down the residents' hands prior to the meal. NA-B stated they did hand hygiene prior to starting to assist the residents with breakfast. NA-B verified they did not perform hand hygiene in between helping residents and used the same hand to feed all 3 residents. NA-B verified residents listed above are dependent on staff for assistance with meals. On 6/13/24 at 11:12 a.m., director of nursing (DON) stated "it's a standard thing" to perform hand hygiene while assisting residents with meals and between residents. DON stated it is important to ensure cross contamination doesn't occur and "they need to clean their hands." The CDC article, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, indicates hand hygiene is an important part of stopping the spread of "deadly germs" to residents including those resistant to antibiotics. The article indicates hand hygiene should be completed after touching a resident or their surroundings, after contact with a contaminated surface, and immediately before touching a resident.	21375		

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21375	Continued From page 25 The facility's Handwashing policy dated 2/24, indicated hand washing should be performed by all employees between tasks and procedures to prevent cross-contamination. F880 - WASH MACHINE During observation of laundry room tour on 6/12/24 at 9:08 a.m., a one-page document was observed hanging on a bulletin board by the entryway door, titled "Any Shift Laundry Routine." The document provided guidelines on what should be done throughout shift indicating the start and end of shift. The start of shift indicated "Load Dryers". At the end of shift, it indicated "Load Washers ....". On 6/12/24 at 9:10 a.m., laundry aide (LA)-A and regional district manager (RDM) present during laundry room tour. LA-A verified they worked full-time in laundry services and were familiar with the job. LA-A and RDM verified the document titled "Any shift laundry routine" was up-to date with expectations. LA-A verified that prior to the end of their shift, they start with wash machines with a load of laundry. LA-A verified the laundry sits in the wash machine through the evening shift and night shift until the next day when staff from the laundry department come in to start their shift. LA-A verified when they start their shift in the morning, they take the laundry from the wash machine, that was started at the end of their shift the day prior and put it in the dry machine. On 6/12/24 at 9:13 a.m., RDM verified that she oversees the department and was covering as the manager was out. When asked about leaving laundry in the wash machine overnight, RDM stated, "We are not supposed to do that anymore, we were told that last year." RDM stated she	21375		

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21375	Continued From page 26 didn't realize it hadn't been updated and would get it corrected. RDM stated leaving wash in the wash machine overnight is of concern "because it could grow bacteria and things on it." On 6/12/24 at 9:38 a.m., administrator stated laundry shouldn't be wet in the wash machine overnight due to "potential bacteria growth". 6/12/24 at 1:43 p.m., RDM stated staff working were provided education regarding not leaving laundry in wash machines overnight, an updated "laundry routine" was hung. RDM stated the remaining laundry staff, and the manager will be in-services upon their return. A facility policy on wet linens/wash machine relating to infection control was requested and not received. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on Enhanced Barrier Precautions and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance	21385		7/17/24

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21385	Continued From page 27 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to utilize infection control practices while administering medications through gastrostomy tube for 1 of 1 residents (R93) observed for medication administration, utilize infection control practices while delivering meal trays to resident rooms for 7 of 7 residents (R35, R53, R58, R59, R64, R67, R112) observed for dining, while assisting multiple residents to eat at once for 7 of 33 residents (R2, R3, R14,R23, R33, R55, R80) observed for dining. In addition, the facility failed to implement and maintain enhanced barrier precautions (EBP) for 2 of 2 resident (R16, R93) reviewed for transmission based precautions. Furthermore, the facility failed to mitigate transmission of potential infections in relation to laundering of linens and personal items. Findings include: Med Admin R93 R93's quarterly Minimum Data Set (MDS) dated 3/28/24 state admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and	21385	corrected.	

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21385	Continued From page 28 Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's physician orders (PO) dated 4/8/22 direct staff to, "Crush each medication in 15ml of warm purified or sterile water and administer each separately using gravity." R93's PO dated 4/22/24 stated, "Before administering medication, stop feeding for 30 minutes and flush the tube with at least 15 milliliters (mL) sterile water." During observation on 6/12/24 at 8:16 a.m., licensed practical nurse (LPN)-A entered R93's room with four medication cups of crushed medications and placed them on his bedside table. LPN-A then obtained the sixty cubic centimeter (cc) piston syringe from his bedside table and added water from a plastic cylinder into each medication cup. LPN-A then paused R93's enteral feeding that was running and removed his abdominal binder to access his GT. LPN-A then auscultated and assessed R93's GT for placement by connecting piston syringe with water in it to R93's GT port and injecting and withdrawing water. LPN-A then disconnected piston syringe from GT port and bent the tubing connected to the resident with her left hand while reaching over to the bedside table and aspirating (withdrawing) medication mixture from one medication cup with her right hand. LPN-A then connected the medication filled piston syringe to the GT port and unbent the GT that was attached to R93. LPN-A then administered medication and bent the GT with left hand and reached over to the bedside table to withdraw another medication. During this process LPN-A allowed the tip of the piston syringe to touch R93's hospital gown several times and used the piston syringe to add more water to the next medication cup. LPN-A then withdrew it into the piston syringe and	21385		

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21385	Continued From page 29 repeated process until all four medications were administered. During administration LPN-A allowed the tip of the piston syringe to touch R93's hospital gown again before adding more water to the piston syringe and flushing the GT port to end the process. LPN-A re-connected enteral feeding tube and re-applied R93's abdominal binder. During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated she had not turned off R93's enteral feeding for thirty minutes prior to administering his medications per PO and, "I should have". Also, "the piston syringe should never touch the resident gown when administering GT meds. Contamination is a concern." During interview with director of nursing (DON) on 6/11/24 at 9:08 a.m., DON stated, "GT feeding tip of piston syringe should not touch gown of resident due to risk of contamination. Staff should [have] replaced it and [sic] get a new one if the end touches anything like the gown of a resident." Facility policy titled Administering Medications through an Enteral Tube updated 3/23/23, "stop the feeding at least 30 minutes prior to medication administration and restart at least 30 minutes after medication administration." And, "Place the end of the tubing on a clean gauze pad positioned on the abdomen or chest of the resident". EBP R16 R16's quarterly MDS dated 4/16/24, stated admission to facility on 12/14/23, had intact cognition, and diagnoses of coronary artery disease (CAD), heart failure, peripheral vascular	21385		

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21385	Continued From page 30 disease, diabetes, depression, and morbid obesity. In addition, 16 at risk for pressure ulcers and had diabetic foot ulcers. R16's physician orders dated 6/11/24 stated, "Wound care: Left Gluteus: Cleanse with wound cleanser. Apply Calmoseptine (ointment). Cover with foam dressing. Every day shift" and "Wound care: Right Gluteus. Cleanse with soap and water. Apply Calmoseptine after peri-care. Every shift". R16's care plan (CP) revised on 5/30/24 stated, "Problem: Resident is currently on Enhanced Barrier Precautions R/T MASD (moisture associated skin damage) on right and left gluteus", and "Problem: Resident is currently on Enhanced Barrier Precautions R/T diabetic ulcer on Left Great toe." During observation and interview on 6/11/24 at 7:12 a.m., R16's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. R16's door and rest of room did not have signage indicating EBP. There was a PPE plastic garbage can with lid on it inside room next to foot of bed. The door was open to the hallway. R16 in electric wheelchair. Two staff members were in the room with a patient lift unit (Hoyer) sling attached to R16 and transfer initiated from wheelchair to bed. Nursing assistant (NA)-D wearing surgical face mask and gloves and no PPE gown. NA-E wearing gloves but no PPE gown. NA-D stated she, "wear [sic] mask sometimes when we go into room. We wear a mask. He [R16] is not on precautions." During observation and interview with registered nurse (RN)-B on 6/11/24 at 7:19 a.m., RN-B	21385		

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21385	Continued From page 31 entered R16 room with gloves and surgical mask but no PPE gown. RN-B assisted with Hoyer transfer of resident to bed. RN-B stated, "[R16] no longer has a wound. Should not be on EBP now." During observation and interview with NA-C on 6/11/24 at 7:33 a.m., NA-C entered R16's room with a surgical mask on and gloves but no PPE gown. NA-C also assisting NA-E, NA-D, and RN-B with direct hands on care for Hoyer transfer from wheelchair to bed. During interview with director of nursing (DON) who is also the infection control preventionist (IC) on 6/11/24 at 8:59 a.m., IC looked in R16's EMR and stated, "Yes, he has a MASD and should be on EBP. Oh wait, it was resolved last week on wound rounds. The nurse manager probably did not remove all of it [signage and PPE equipment]. She should have after the wound rounds." IC stated R16's EMR lacked progress notes or wound care notes indicating R16 was to come off of EBP prior to 6/11/24. IC stated staff wound not be aware of any changes or updates unless there was documentation to support it in the EMR and would expect all staff to follow EBP for R16 until the EMR was updated. R93 R93's care plan (CP) dated 4/3/24 state a focus of, "Problem: Resident is currently on Enhanced Barrier Precautions R/T enteral feeding" with "Interventions/Tasks" of, "-Staff to follow Enhanced Barrier Precautions, -Staff to don/doff PPE (personal protective equipment) per enhanced barrier precautions when providing high contact cares". R93's physician orders dated 4/23/24 state,	21385		

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21385	Continued From page 32 "Resident is currently on Enhanced Barrier Precautions for Enteral Feed every shift". During observation and interview on 6/10/24 at 1:36 p.m., the shared room for R57 and R93's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. Signage posted on the door frame stated EBP expectation for staff who care for R93 to wear PPE gown and gloves when providing direct hands on care such as transferring. No PPE garbage can was observed inside or outside R93's room. NA-B exited room without a PPE gown, asking for licensed practical nurse (LPN)-A for assistance with transferring R93 into bed. LPN-A entered room with PPE gown, gloves, and surgical mask. LPN-A stated, R93 on EBP due to, "He had a wound on the side of his knee." NA-B put on a PPE gown from the door unit and then entered R93 room. Both NA-B and LPN-A transferred R93 to bed using the Hoyer. After the transfer was completed, LPN-A exited room with her PPE gown, gloves and mask on and walked down the hall towards the nursing station. LPN-A did not wash her hands prior to exiting the room. NA-B removed gown and gloves and placed the used PPE into a plastic garbage can liner and closed it prior to exiting R93's room. NA-B was unaware of PPE garbage can ever being present in R93's room. During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated, "the PPE garbage should always [sic] in the [R93] room due to EBP. It was put in there yesterday after you [surveyor] was in here". LPN-A stated, "I should not have walked out of his room with the gown and gloves on when we were transferring him. I should have removed them in the room and put them in a bag or something and then sanitized my hands before	21385		

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21385	Continued From page 33 exiting the room [sic] and re-applied the gown and gloves before going back into his room to help [NA-B] with the Hoyer transfer." During interview with IC on 6/11/24 at 8:59 a.m., IC stated, "staff should not be exiting EBP rooms with face mask, gown and gloves on." IC stated expectation of staff to follow EBP signage instructions to don and doff PPE when working with residents that have EBP signage posted on their doors. Facility policy titled Enhanced Barrier Precautions revised 4/1/24, state, "[EBP] refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi-drug resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)." Further, "Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions" and initiation of EBP for residents with wounds and indwelling medical devices (such as feeding tubes). Also, "Position a trash can inside the resident room for discarding PPE (personal protective equipment) after removal, prior to exit of the room". High -contact resident care activities include, "Dressing, Bathing, Transferring, Providing hygiene, Changing linens, Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and Wound care: any skin opening requiring a dressing." DINING/ HAND HYGIENE: During observation on 6/12/24 at 8:37 a.m., certified nursing assistant (CNA)-O was passing out breakfast trays to residents in the third-floor	21385		

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21385	Continued From page 34 dining room. CNA-O then sat down to assist R2 with eating without performing hand hygiene. During observation on 6/12/24 at 8:45 a.m., CNA-O stopped assisting R2 with eating her breakfast and started assisting R23 with her breakfast without performing hang hygiene in between residents. During observation on 6/12/24 at 8:52 a.m., CNA-J was sitting between R14 and R55, assisting them both with eating their breakfast, switching between each residents' utensils with the same hand. CNA-J did not perform hand hygiene in between. R55 was noted to have a wet, non-productive cough. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated the expectation was for the CNAs to perform hand hygiene before assisting residents with eating. During an interview on 6/13/24 at 1:51 p.m., the infection preventionist and director of nursing (DON) stated hand hygiene was expected before and after assisting residents with eating and in between residents if the same hand is being used to assist. R35's annual Minimum Data Set (MDS) dated 5/8/24, indicated R35 had intact cognition and was diagnosed with heart failure, kidney failure, diabetes, and respiratory failure. R53's quarterly MDS dated 2/7/24, indicated R53 had moderately impaired cognition and was diagnosed with diabetes, a stroke, and malnutrition. The MDS indicated that R53 required a feeding tube and a mechanically	21385		

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21385	Continued From page 35 altered diet. R53's order summary report dated 4/23/24, indicated R53 was on enhanced barrier precautions "for enteral feed". R58's quarterly MDS dated 3/7/24, indicated R58 had intact cognition and was diagnosed with heart failure, diabetes, and asthma. R59's quarterly MDS dated 3/26/24, indicated R59 had intact cognition and was diagnosed with anemia, depression, and anxiety. The MDS indicated the presence of a surgical wound. R59's order summary report dated 6/10/24, indicated R59 had a wound and was on enhanced barrier precautions. R64's quarterly MDS dated 5/1/24, indicated R64 had intact cognition and was diagnosed with anemia and malnutrition. R67's quarterly MDS dated 3/13/24, indicated R67 had intact cognition and was diagnosed with a leg fracture. R112's quarterly MDS dated 3/28/24, indicated R112 had intact cognition and was diagnosed with kidney disease, diabetes, and hypertension. During an observation on 6/10/24 at 5:54 p.m., nursing assistants (NA)-H and NA-I were observed pushing a tall cart containing meal trays down the hallway toward resident rooms. NA-H was observed to enter R53's room with a meal tray in hand. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. A sign indicating R53 was	21385		

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21385	Continued From page 36 on enhanced barrier precautions and "everyone must: clean their hands, including before entering and when leaving the room" was observed on the door. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R58's room tray from the cart and enter R58's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R35's room tray from the cart and enter R35's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. No hand hygiene upon entering or exiting the room was observed. During an observation on 6/10/24 at 6:00 p.m., NA-I was observed to enter R64's room with a meal tray, move personal items on the table, and exit the room. No hand hygiene was observed. NA-I was then observed to grab R67's tray, enter the resident's room, set the tray on the table, and exit. No hand hygiene was observed. NA-I was observed to grab R59's food tray, enter the resident's room, move items on the resident's table, and remove used-looking cup. A sign indicating R59 was on enhanced barrier precautions and "everyone must: clean their hands, including before entering and when leaving the room" was observed on the door. NA-I exited the room, and no hand hygiene was observed. NA-I was observed to grab the meal tray for R112 and enter the resident's room. During an interview on 6/10/24 at 6:03 p.m. with NA-H and NA-I, NA-H stated they were taught to complete hand hygiene before starting to pass	21385		

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21385	Continued From page 37 meal trays and when they are completed with all of the trays but not between individual rooms and NA-I agreed. NA-H and NA-I acknowledged they had not completed hand hygiene before entering and exiting the rooms above including the residents on enhanced barrier precautions. During an interview on 6/13/24 at 1:45 p.m., the director of nursing (DON) stated she expected the NAs to complete hand hygiene before and after a resident room while passing room trays to prevent the possible spread of infection. On 6/12/24 at 8:19 a.m., on 3rd floor dining room in men's care memory unit, it was observed staff assisting resident with breakfast. Nursing assistant (NA)-B alternating between feeding R80, R3 and R33. NA-B was observed using primarily one hand to assist the residents to eat. On 6/12/24 at 10:57 a.m., NA-B verified they were assisting 3 residents at the same time during breakfast today and verified the residents listed above. NA-B stated they wiped down the residents' hands prior to the meal. NA-B stated they did hand hygiene prior to starting to assist the residents with breakfast. NA-B verified they did not perform hand hygiene in between helping residents and used the same hand to feed all 3 residents. NA-B verified residents listed above are dependent on staff for assistance with meals. On 6/13/24 at 11:12 a.m., director of nursing (DON) stated "it's a standard thing" to perform hand hygiene while assisting residents with meals and between residents. DON stated it is important to ensure cross contamination doesn't occur and "they need to clean their hands." The CDC article, Clinical Safety: Hand Hygiene	21385		

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21385	Continued From page 38 for Healthcare Workers, dated 2/27/24, indicates hand hygiene is an important part of stopping the spread of "deadly germs" to residents including those resistant to antibiotics. The article indicates hand hygiene should be completed after touching a resident or their surroundings, after contact with a contaminated surface, and immediately before touching a resident. The facility's Handwashing policy dated 2/24, indicated hand washing should be performed by all employees between tasks and procedures to prevent cross-contamination. F880 - WASH MACHINE During observation of laundry room tour on 6/12/24 at 9:08 a.m., a one-page document was observed hanging on a bulletin board by the entryway door, titled "Any Shift Laundry Routine." The document provided guidelines on what should be done throughout shift indicating the start and end of shift. The start of shift indicated "Load Dryers". At the end of shift, it indicated "Load Washers ....". On 6/12/24 at 9:10 a.m., laundry aide (LA)-A and regional district manager (RDM) present during laundry room tour. LA-A verified they worked full-time in laundry services and were familiar with the job. LA-A and RDM verified the document titled "Any shift laundry routine" was up-to date with expectations. LA-A verified that prior to the end of their shift, they start with wash machines with a load of laundry. LA-A verified the laundry sits in the wash machine through the evening shift and night shift until the next day when staff from the laundry department come in to start their shift. LA-A verified when they start their shift in the morning, they take the laundry from the wash	21385		

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21385	Continued From page 39 machine, that was started at the end of their shift the day prior and put it in the dry machine. On 6/12/24 at 9:13 a.m., RDM verified that she oversees the department and was covering as the manager was out. When asked about leaving laundry in the wash machine overnight, RDM stated, "We are not supposed to do that anymore, we were told that last year." RDM stated she didn't realize it hadn't been updated and would get it corrected. RDM stated leaving wash in the wash machine overnight is of concern "because it could grow bacteria and things on it." On 6/12/24 at 9:38 a.m., administrator stated laundry shouldn't be wet in the wash machine overnight due to "potential bacteria growth". 6/12/24 at 1:43 p.m., RDM stated staff working were provided education regarding not leaving laundry in wash machines overnight, an updated "laundry routine" was hung. RDM stated the remaining laundry staff, and the manager will be in-services upon their return. A facility policy on wet linens/wash machine relating to infection control was requested and not received. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should re-educate nursing staff to appropriately implement correct hand hygiene when assisting residents in the dining room. The DON or designee could review and revise dining policies to ensure appropriateness. The DON or designee should perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to	21385		

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21385	Continued From page 40 determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced	21390		7/17/24

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21390	Continued From page 41 by: Based on observation, interview, and document review, the facility failed to utilize infection control practices while administering medications through gastrostomy tube for 1 of 1 residents (R93) observed for medication administration, utilize infection control practices while delivering meal trays to resident rooms for 7 of 7 residents (R35, R53, R58, R59, R64, R67, R112) observed for dining, while assisting multiple residents to eat at once for 7 of 33 residents (R2, R3, R14,R23, R33, R55, R80) observed for dining. In addition, the facility failed to implement and maintain enhanced barrier precautions (EBP) for 2 of 2 resident (R16, R93) reviewed for transmission based precautions. Furthermore, the facility failed to mitigate transmission of potential infections in relation to laundering of linens and personal items. Findings include: Med Admin R93's quarterly Minimum Data Set (MDS) dated 3/28/24 state admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's physician orders (PO) dated 4/8/22 direct staff to, "Crush each medication in 15ml of warm purified or sterile water and administer each separately using gravity." R93's PO dated 4/22/24 stated, "Before administering medication, stop feeding for 30 minutes and flush the tube with at least 15 milliliters (mL) sterile water."	21390	corrected.	

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21390	Continued From page 42 During observation on 6/12/24 at 8:16 a.m., licensed practical nurse (LPN)-A entered R93's room with four medication cups of crushed medications and placed them on his bedside table. LPN-A then obtained the sixty cubic centimeter (cc) piston syringe from his bedside table and added water from a plastic cylinder into each medication cup. LPN-A then paused R93's enteral feeding that was running and removed his abdominal binder to access his GT. LPN-A then auscultated and assessed R93's GT for placement by connecting piston syringe with water in it to R93's GT port and injecting and withdrawing water. LPN-A then disconnected piston syringe from GT port and bent the tubing connected to the resident with her left hand while reaching over to the bedside table and aspirating (withdrawing) medication mixture from one medication cup with her right hand. LPN-A then connected the medication filled piston syringe to the GT port and unbent the GT that was attached to R93. LPN-A then administered medication and bent the GT with left hand and reached over to the bedside table to withdraw another medication. During this process LPN-A allowed the tip of the piston syringe to touch R93's hospital gown several times and used the piston syringe to add more water to the next medication cup. LPN-A then withdrew it into the piston syringe and repeated process until all four medications were administered. During administration LPN-A allowed the tip of the piston syringe to touch R93's hospital gown again before adding more water to the piston syringe and flushing the GT port to end the process. LPN-A re-connected enteral feeding tube and re-applied R93's abdominal binder. During interview with LPN-A on 6/11/24 at 8:42	21390		

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21390	Continued From page 43 a.m., LPN-A stated she had not turned off R93's enteral feeding for thirty minutes prior to administering his medications per PO and, "I should have". Also, "the piston syringe should never touch the resident gown when administering GT meds. Contamination is a concern." During interview with director of nursing (DON) on 6/11/24 at 9:08 a.m., DON stated, "GT feeding tip of piston syringe should not touch gown of resident due to risk of contamination. Staff should [have] replaced it and [sic] get a new one if the end touches anything like the gown of a resident." Facility policy titled Administering Medications through an Enteral Tube updated 3/23/23, "stop the feeding at least 30 minutes prior to medication administration and restart at least 30 minutes after medication administration." And, "Place the end of the tubing on a clean gauze pad positioned on the abdomen or chest of the resident". EBP R16's quarterly MDS dated 4/16/24, stated admission to facility on 12/14/23, had intact cognition, and diagnoses of coronary artery disease (CAD), heart failure, peripheral vascular disease, diabetes, depression, and morbid obesity. In addition, 16 at risk for pressure ulcers and had diabetic foot ulcers. R16's physician orders dated 6/11/24 stated, "Wound care: Left Gluteus: Cleanse with wound cleanser. Apply Calmoseptine (ointment). Cover with foam dressing. Every day shift" and "Wound care: Right Gluteus. Cleanse with soap and water. Apply Calmoseptine after peri-care. Every	21390		

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21390	Continued From page 44 shift". R16's care plan (CP) revised on 5/30/24 stated, "Problem: Resident is currently on Enhanced Barrier Precautions R/T MASD (moisture associated skin damage) on right and left gluteus", and "Problem: Resident is currently on Enhanced Barrier Precautions R/T diabetic ulcer on Left Great toe." During observation and interview on 6/11/24 at 7:12 a.m., R16's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. R16's door and rest of room did not have signage indicating EBP. There was a PPE plastic garbage can with lid on it inside room next to foot of bed. The door was open to the hallway. R16 in electric wheelchair. Two staff members were in the room with a patient lift unit (Hoyer) sling attached to R16 and transfer initiated from wheelchair to bed. Nursing assistant (NA)-D wearing surgical face mask and gloves and no PPE gown. NA-E wearing gloves but no PPE gown. NA-D stated she, "wear [sic] mask sometimes when we go into room. We wear a mask. He [R16] is not on precautions." During observation and interview with registered nurse (RN)-B on 6/11/24 at 7:19 a.m., RN-B entered R16 room with gloves and surgical mask but no PPE gown. RN-B assisted with Hoyer transfer of resident to bed. RN-B stated, "[R16] no longer has a wound. Should not be on EBP now." During observation and interview with NA-C on 6/11/24 at 7:33 a.m., NA-C entered R16's room with a surgical mask on and gloves but no PPE gown. NA-C also assisting NA-E, NA-D, and	21390		

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21390	Continued From page 45 RN-B with direct hands on care for Hoyer transfer from wheelchair to bed. During interview with director of nursing (DON) who is also the infection control preventionist (IC) on 6/11/24 at 8:59 a.m., IC looked in R16's EMR and stated, "Yes, he has a MASD and should be on EBP. Oh wait, it was resolved last week on wound rounds. The nurse manager probably did not remove all of it [signage and PPE equipment]. She should have after the wound rounds." IC stated R16's EMR lacked progress notes or wound care notes indicating R16 was to come off of EBP prior to 6/11/24. IC stated staff wound not be aware of any changes or updates unless there was documentation to support it in the EMR and would expect all staff to follow EBP for R16 until the EMR was updated. R93 R93's care plan (CP) dated 4/3/24 state a focus of, "Problem: Resident is currently on Enhanced Barrier Precautions R/T enteral feeding" with "Interventions/Tasks" of, "-Staff to follow Enhanced Barrier Precautions, -Staff to don/doff PPE (personal protective equipment) per enhanced barrier precautions when providing high contact cares". R93's physician orders dated 4/23/24 state, "Resident is currently on Enhanced Barrier Precautions for Enteral Feed every shift". During observation and interview on 6/10/24 at 1:36 p.m., the shared room for R57 and R93's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. Signage posted on the door frame stated EBP expectation for staff who care for R93 to wear PPE gown and gloves when	21390		

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21390	Continued From page 46 providing direct hands on care such as transferring. No PPE garbage can was observed inside or outside R93's room. NA-B exited room without a PPE gown, asking for licensed practical nurse (LPN)-A for assistance with transferring R93 into bed. LPN-A entered room with PPE gown, gloves, and surgical mask. LPN-A stated, R93 on EBP due to, "He had a wound on the side of his knee." NA-B put on a PPE gown from the door unit and then entered R93 room. Both NA-B and LPN-A transferred R93 to bed using the Hoyer. After the transfer was completed, LPN-A exited room with her PPE gown, gloves and mask on and walked down the hall towards the nursing station. LPN-A did not wash her hands prior to exiting the room. NA-B removed gown and gloves and placed the used PPE into a plastic garbage can liner and closed it prior to exiting R93's room. NA-B was unaware of PPE garbage can ever being present in R93's room. During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated, "the PPE garbage should always [sic] in the [R93] room due to EBP. It was put in there yesterday after you [surveyor] was in here". LPN-A stated, "I should not have walked out of his room with the gown and gloves on when we were transferring him. I should have removed them in the room and put them in a bag or something and then sanitized my hands before exiting the room [sic] and re-applied the gown and gloves before going back into his room to help [NA-B] with the Hoyer transfer." During interview with IC on 6/11/24 at 8:59 a.m., IC stated, "staff should not be exiting EBP rooms with face mask, gown and gloves on." IC stated expectation of staff to follow EBP signage instructions to don and doff PPE when working with residents that have EBP signage posted on	21390		

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21390	Continued From page 47 their doors. Facility policy titled Enhanced Barrier Precautions revised 4/1/24, state, "[EBP] refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi-drug resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)." Further, "Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions" and initiation of EBP for residents with wounds and indwelling medical devices (such as feeding tubes). Also, "Position a trash can inside the resident room for discarding PPE (personal protective equipment) after removal, prior to exit of the room". High -contact resident care activities include, "Dressing, Bathing, Transferring, Providing hygiene, Changing linens, Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and Wound care: any skin opening requiring a dressing." DINING/ HAND HYGIENE: During observation on 6/12/24 at 8:37 a.m., certified nursing assistant (CNA)-O was passing out breakfast trays to residents in the third-floor dining room. CNA-O then sat down to assist R2 with eating without performing hand hygiene. During observation on 6/12/24 at 8:45 a.m., CNA-O stopped assisting R2 with eating her breakfast and started assisting R23 with her breakfast without performing hang hygiene in between residents. During observation on 6/12/24 at 8:52 a.m.,	21390		

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21390	Continued From page 48 CNA-J was sitting between R14 and R55, assisting them both with eating their breakfast, switching between each residents' utensils with the same hand. CNA-J did not perform hand hygiene in between. R55 was noted to have a wet, non-productive cough. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated the expectation was for the CNAs to perform hand hygiene before assisting residents with eating. During an interview on 6/13/24 at 1:51 p.m., the infection preventionist and director of nursing (DON) stated hand hygiene was expected before and after assisting residents with eating and in between residents if the same hand is being used to assist. R35's annual Minimum Data Set (MDS) dated 5/8/24, indicated R35 had intact cognition and was diagnosed with heart failure, kidney failure, diabetes, and respiratory failure. R53's quarterly MDS dated 2/7/24, indicated R53 had moderately impaired cognition and was diagnosed with diabetes, a stroke, and malnutrition. The MDS indicated that R53 required a feeding tube and a mechanically altered diet. R53's order summary report dated 4/23/24, indicated R53 was on enhanced barrier precautions "for enteral feed". R58's quarterly MDS dated 3/7/24, indicated R58 had intact cognition and was diagnosed with heart failure, diabetes, and asthma.	21390		

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21390	Continued From page 49 R59's quarterly MDS dated 3/26/24, indicated R59 had intact cognition and was diagnosed with anemia, depression, and anxiety. The MDS indicated the presence of a surgical wound. R59's order summary report dated 6/10/24, indicated R59 had a wound and was on enhanced barrier precautions. R64's quarterly MDS dated 5/1/24, indicated R64 had intact cognition and was diagnosed with anemia and malnutrition. R67's quarterly MDS dated 3/13/24, indicated R67 had intact cognition and was diagnosed with a leg fracture. R112's quarterly MDS dated 3/28/24, indicated R112 had intact cognition and was diagnosed with kidney disease, diabetes, and hypertension. During an observation on 6/10/24 at 5:54 p.m., nursing assistants (NA)-H and NA-I were observed pushing a tall cart containing meal trays down the hallway toward resident rooms. NA-H was observed to enter R53's room with a meal tray in hand. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. A sign indicating R53 was on enhanced barrier precautions and "everyone must: clean their hands, including before entering and when leaving the room" was observed on the door. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R58's room tray from the cart and enter R58's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. No hand hygiene upon	21390		

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21390	Continued From page 50 entering or exiting the room was observed. NA-H was then observed to grab R35's room tray from the cart and enter R35's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. No hand hygiene upon entering or exiting the room was observed. During an observation on 6/10/24 at 6:00 p.m., NA-I was observed to enter R64's room with a meal tray, move personal items on the table, and exit the room. No hand hygiene was observed. NA-I was then observed to grab R67's tray, enter the resident's room, set the tray on the table, and exit. No hand hygiene was observed. NA-I was observed to grab R59's food tray, enter the resident's room, move items on the resident's table, and remove used-looking cup. A sign indicating R59 was on enhanced barrier precautions and "everyone must: clean their hands, including before entering and when leaving the room" was observed on the door. NA-I exited the room, and no hand hygiene was observed. NA-I was observed to grab the meal tray for R112 and enter the resident's room. During an interview on 6/10/24 at 6:03 p.m. with NA-H and NA-I, NA-H stated they were taught to complete hand hygiene before starting to pass meal trays and when they are completed with all of the trays but not between individual rooms and NA-I agreed. NA-H and NA-I acknowledged they had not completed hand hygiene before entering and exiting the rooms above including the residents on enhanced barrier precautions. During an interview on 6/13/24 at 1:45 p.m., the director of nursing (DON) stated she expected the NAs to complete hand hygiene before and	21390		

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21390	Continued From page 51 after a resident room while passing room trays to prevent the possible spread of infection. On 6/12/24 at 8:19 a.m., on 3rd floor dining room in men's care memory unit, it was observed staff assisting resident with breakfast. Nursing assistant (NA)-B alternating between feeding R80, R3 and R33. NA-B was observed using primarily one hand to assist the residents to eat. On 6/12/24 at 10:57 a.m., NA-B verified they were assisting 3 residents at the same time during breakfast today and verified the residents listed above. NA-B stated they wiped down the residents' hands prior to the meal. NA-B stated they did hand hygiene prior to starting to assist the residents with breakfast. NA-B verified they did not perform hand hygiene in between helping residents and used the same hand to feed all 3 residents. NA-B verified residents listed above are dependent on staff for assistance with meals. On 6/13/24 at 11:12 a.m., director of nursing (DON) stated "it's a standard thing" to perform hand hygiene while assisting residents with meals and between residents. DON stated it is important to ensure cross contamination doesn't occur and "they need to clean their hands." The CDC article, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, indicates hand hygiene is an important part of stopping the spread of "deadly germs" to residents including those resistant to antibiotics. The article indicates hand hygiene should be completed after touching a resident or their surroundings, after contact with a contaminated surface, and immediately before touching a resident. The facility's Handwashing policy dated 2/24,	21390		

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21390	Continued From page 52 indicated hand washing should be performed by all employees between tasks and procedures to prevent cross-contamination. F880 - WASH MACHINE During observation of laundry room tour on 6/12/24 at 9:08 a.m., a one-page document was observed hanging on a bulletin board by the entryway door, titled "Any Shift Laundry Routine." The document provided guidelines on what should be done throughout shift indicating the start and end of shift. The start of shift indicated "Load Dryers". At the end of shift, it indicated "Load Washers ....". On 6/12/24 at 9:10 a.m., laundry aide (LA)-A and regional district manager (RDM) present during laundry room tour. LA-A verified they worked full-time in laundry services and were familiar with the job. LA-A and RDM verified the document titled "Any shift laundry routine" was up-to date with expectations. LA-A verified that prior to the end of their shift, they start with wash machines with a load of laundry. LA-A verified the laundry sits in the wash machine through the evening shift and night shift until the next day when staff from the laundry department come in to start their shift. LA-A verified when they start their shift in the morning, they take the laundry from the wash machine, that was started at the end of their shift the day prior and put it in the dry machine. On 6/12/24 at 9:13 a.m., RDM verified that she oversees the department and was covering as the manager was out. When asked about leaving laundry in the wash machine overnight, RDM stated, "We are not supposed to do that anymore, we were told that last year." RDM stated she didn't realize it hadn't been updated and would	21390		

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21390	Continued From page 53 get it corrected. RDM stated leaving wash in the wash machine overnight is of concern "because it could grow bacteria and things on it." On 6/12/24 at 9:38 a.m., administrator stated laundry shouldn't be wet in the wash machine overnight due to "potential bacteria growth". 6/12/24 at 1:43 p.m., RDM stated staff working were provided education regarding not leaving laundry in wash machines overnight, an updated "laundry routine" was hung. RDM stated the remaining laundry staff, and the manager will be in-services upon their return. A facility policy on wet linens/wash machine relating to infection control was requested and not received. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program including GT medication administration process to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		
21440	MN Rule 4658.0900 Subp. 2 Activity and Recreation Program; Frequency	21440		7/17/24

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21440	Continued From page 54 Subp. 2. Frequency of program activities. The activity and recreation program must be regularly scheduled every day, except that a nursing home may establish a policy designating holidays or other days that are exempt from scheduled activities. A schedule of the activities and recreation programming must be posted in a location readily accessible to residents at least one week in advance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident's preferred activities for individual entertainment were available for 1 or 1 residents (R93) reviewed for activities. Additionally, facility failed to comprehensively assess for, and provide, individualized activities for 1 of 1 transitional care unit (TCU) resident (R106). Findings include: R93's quarterly Minimum Data Set (MDS) assessment dated 3/28/24 indicates admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). In addition, R93's "preferred language" was documented as "OTHER". R93's Therapy Recreation Evaluation and Social History evaluation on 4/6/22 state R93 nationality of Vietnamese, and enjoyed "fishing, listening to music and watching movies." R93's care plan (CP) dated 4/7/22 with a focus of, "1) Alteration in socialization, potential for activity deficit r/t Parkinson's and Hemiplegia with mobility deficit, Communication deficit". CP	21440	corrected.	

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21440	Continued From page 55 Intervention dated 4/18/22 state, "Provide 1:1 activities offered as resident is willing to accept them." A CP intervention dated, 10/3/22 direct staff to, "Offer one to one visits to include: reminiscing, discussion of family, life history, current events, historical facts, and other interests." R93's quarterly Care Conference Form, dated 2/19/24, state, "Resident participates in independent activities like looking out the window, family visits, 1:1 staff visits". R93's May and June 2024 Therapeutic Recreation record indicate R93 not provided or offered activities for May 10, 11, 12, 18, 19, 24, 25, 26, 30th and June 1, 2, 9, and 11th. During interview with family member (FM)-A and primary emergency contact on 6/10/24 at 3:36 p.m., FM-A stated, "I would like them [facility] to move him [R93] next to a window." And "When [R93] first got there [admitted to facility] he was next to window but roommate wanted it too, so they [facility] moved him [away from window]. [R93] is very cooped up. Activities has not worked with him. [R93] used to have TV and now he doesn't". FM-A stated watching TV and window watching was an enjoyable activity for R93 before admission to facility. During interview with licensed practical nurse (LPN)-A on 6/11/24 at 8:38 a.m., LPN-A stated she was "very familiar with [R93]". LPN-A was unaware of R93's preference to watch TV and sit by a window. During interview with nursing assistant (NA)-F on 6/12/24 at 7:45 a.m., NA-F stated, "activities will come in the room but [I] don't know what he does." NA-F was unaware of R93's preference to watch TV and sit by a window. During interview with director of nursing (DON) on 6/13/24 at 8:32 a.m., DON stated, "activities department will set up and arrange [R93]	21440		

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21440	Continued From page 56 activities". During interview with therapeutic director (TR) on 6/13/24 at 10:44 a.m., TR stated expectation of therapeutic recreation staff to communicate with TR about what activities were provided and which residents attended the activities being offered. Then, TR would document in the Therapy Recreation form for each resident in their EMR. TR stated he was familiar with R93 and looked in the R93's EMR. TR stated R93 did not have "visits on the weekends" and that R93 did not have a TV or radio in his room. R106's significant change Minimum Data Set (MDS) assessment, dated 5/22/24, indicated R106 had severe cognitive impairment, was dependent on staff for activities of daily living, and was admitted to the facility on 4/11/24. R106's Associated Clinic of Psychology (ACP) note, dated 4/15/24, indicated treatment recommendations including, R106 was "reporting feeling bored and lonely. He may benefit from multiple strategies such as leaving the TV on his favorite channel, having music playing, one-to-one type activities, visits from family and other similar strategies may mitigate distress and improve quality of life. He may also like colorful blankets or stimulus that could be made available in his room."	21440		

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21440	Continued From page 57 R106 ACP note, dated 5/13/24, indicated R106 stated "he would like to participate more in things like music, TV shows, pet therapy and being read to. He is a good candidate for one-to-one type activities to be engaged in something like reading him. He continues to say he is depressed and anxious and will need strategies such as listening to music on headsets to help shift his thinking and mood." R106's electronic medical record (EMR) lacked an initial Therapeutic Recreational Evaluation and Social History form. R106's Admission Interdisciplinary Team (IDT) Note, dated 4/16/24, indicated R106 "stated interest in structured and non-structured programming" and was "able to decide participation level in structured and non-structured programs." R106's Quarterly IDT Note, dated 5/30/24, indicated R106 "stated interest in structured and non-structured programming" and preferred "independent leisure of choice." R106's Tasks documentation for activity participation for the month of June, printed 7/13/24, indicated different choices of activities for participation to document on such as TV room in group, wheelchair rides, 1:1 visits, group movies, group activities, family or friend visit, community outings, pet visits, socializing with others, sensory stimulation, group music, massage, etc., with an option for Active, Passive, Observation, or Independent participation. R106 had activity 27 (looking out the window/music/time spent in room) documented at 13:59 on the 4th, 5th, 6th, 7th, 8th, 10th, and 12th	21440		

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21440	Continued From page 58 with participation listed as "P" for passive for his activity participation. During observation on 6/10/24 at 3:22 p.m., R106 was heard yelling out from his room, calling for staff, asking if he was going to get medications. R106 was laying in his bed in a hospital gown, with the door to his room half closed. No music was heard in the room and the TV was not on. During observation on 6/11/24 at 2:34 p.m. and 6/12/24 at 11:40 a.m., R106 was up in his wheelchair in his room, alone and without staff interaction, watching TV. During an interview on 6/13/24 at 11:02 a.m., the Therapeutic Recreational Director (TR) stated all residents, both transitional care and long-term residents, would be assessed at admission for social history and activities of interest using the Therapeutic Recreational Evaluation and Social History form. This form was used to create an individualized care plan and so staff was aware of what activities to invite residents to and what their interests were. The TR confirmed R106 did not have an initial assessment completed. During an interview on 6/13/24 at 12:20 p.m., nursing assistant (NA)-N stated R106 would voice feeling bored, stating he wanted to go home and "get out of here." NA-N stated R106 liked "fast cars and motorcycles" and had been asking for a radio lately but did not have one. During an interview on 6/13/24 at 12:23 p.m., an unnamed recreational therapy aide confirmed they did have a radio for residents to use. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) stated the expectation	21440		

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21440	Continued From page 59 was for all residents, including TCU residents, to be comprehensively assessed by the therapeutic recreation department upon admission. Facility policy on activities was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, activities director or designee, could engage the interdisciplinary team (IDT) to ensure residents in the facility were provided meaningful activities to meet thier interests and include activities on evenings and weekends. Activities selected should be resident-centered. The administrator or designee could seek advice from resident council on likes and dislikes of types and kinds of activities offered in the facility. Activities should incorporate the resident's interests, hobbies and cultural preferences, integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence and promote self-esteem, pleasure, comfort, education, creativity, success, and independence. ADL-related activities, such as manicures or pedicures, hair styling, and makeovers, may be considered part of the activities program. Activities selected should be individualized and customized based on the resident's previous lifestyle (occupation, family, hobbies), preferences and comforts. Activities should not be confined to a department, but rather may involve all staff interacting with residents. Activities could be non-structured. The administrator or designee could ensure any activities supplied to residents in this manner be care-planned and documented in the residents ' medical record and audited. The results of those audits should be taken to QAPI to determine compliance or the need for continued monitoring.	21440		

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21440	Continued From page 60 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21440		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality	21530		7/17/24

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21530	Continued From page 61 assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to address and respond to the consulting pharmacist's (CP) medication regiment review (MRR) for 2 of 5 residents (R75 and R83) receiving psychotropics (a psychoactive medication taken to exert an effect on the chemical makeup of the brain and nervous system) reviewed for unnecessary medications. Findings include: R75's quarterly Minimum Data Set (MDS) assessment, dated 5/9/24, indicated R75 was admitted to the facility on 1/14/21, had severe cognitive impairment, was independent with ambulation and was receiving the following medications during the look back period; antipsychotics, antianxiety, antidepressants, and opioids. R75's MRR, dated 4/26/24, indicated it was unclear if R75's falls were related to medication and recommended considering reducing R75's Hydroxyzine order to 25 mg at 2:00 p.m. The report included: R75 had multiple falls within the past month and was receiving the following medications that may increase fall risk; Citalopram 20 milligrams (mg) daily (a medication used to treat depression, including major depressive disorder), Hydroxyzine 50 mg three times a day (a medication used to treat anxiety,	21530	corrected.	

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21530	Continued From page 62 nausea, vomiting, allergies, skin rash, hives, and itching), Lisinopril 5 mg daily (a medication used to treat high blood pressure and heart failure), Seroquel 50 mg twice a day (a psychotropic medication used to treat schizophrenia and bipolar disorder), and Lorazepam 1 mg daily (a benzodiazepine used to treat anxiety). R75's electronic medical record (EMR), including the MRR, lacked evidence of physician or prescriber response or follow-up. R75's care plan, dated 4/1/24 - 6/13/24, indicated R75 had five falls on the following dates; 5/26/24 (lowered to the floor due to perceived dizziness), 5/15/24, 5/13/24, 4/24/24, and 4/11/24. R83's quarterly MDS assessment, dated 3/12/24, indicated R83 was admitted to the facility on 11/17/23, had severe cognitive impairment, was independent with ambulation, and received the following medications during the look back period; antipsychotics and antidepressants. R83's Medical Diagnoses, printed 6/13/24, indicated R83 had several medical diagnoses including unspecified dementia with behavioral disturbances, atrial fibrillation, hypertension, chronic kidney disease, atherosclerotic heart disease, major depressive disorder, generalized anxiety, presence of cardiac pacemaker, obesity, fatigue and personal history of transient ischemic attack and cerebral infarction without deficits. R83's MRR, dated 4/26/24, indicated, the Seroquel lacked an appropriate diagnosis, indicating dementia with behavioral disturbances but lacked psychotic features of dementia (i.e., hallucinations, paranoia, delusions) and a review of whether antipsychotic use was necessary. The	21530		

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21530	Continued From page 63 report included: R83 was receiving the following medications; Seroquel 25 mg three times a day, Mirtazapine 7.5 mg every evening (an antidepressant used to treat depression), and Depakote extended release 125 mg daily and 500mg every evening (an anticonvulsant used to treat seizures and bipolar disorder). R83's order for Seroquel, dated 5/14/24, indicated R83 was receiving Seroquel for schizophrenia. R83's EMR lacked documented evidence of provider/prescriber follow up or response on the necessity of antipsychotic use. R83's MRR, dated 5/24/24, indicated to clarify the indication of Seroquel use as it was changed to Schizophrenia and R83 lacked an actual documented diagnosis of Schizophrenia. R83's EMR lacked evidence of a follow up response. During an interview on 6/13/24 at 12:35 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated each director of nursing (DON) had their own process for addressing the MRR's. LPN-D stated the current process was for the DON to send the CP's MRR's to the clinical coordinators via email. If the recommendation was nursing related (i.e., orthostatic blood pressures, target behaviors) the clinical coordinator would address it. If the recommendation was for the provider (i.e., changing medication orders or diagnoses) the MRR was put into the provider mailbox for addressing. CONSULTANT PHARMACIST WAS CALLED TWICE WITH NO RESPONSE During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) stated they were aware	21530		

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21530	Continued From page 64 the process for MRR's was not working, stating with turnover of the health unit coordinator the MRR forms were ending up in the wrong box leading to MRR follow up being missed. A facility policy titled Medication Regiment Review, dated August 2019, indicated MRR recommendations would be documented and acted upon by the facility staff and/or prescriber, indicating the prescriber would accept and act upon the suggestion or reject the suggestion and provide an explanation for disagreeing. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for ensuring medication regiment review recommendatios are addressed and follow up on timely. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in	21535		7/17/24

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21535	Continued From page 65 part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident taking an antipsychotic medication had an appropriate diagnosis for use and was monitored for target behaviors for 1 of 5 residents (R83) reviewed for unnecessary medications. Findings include: R83's quarterly Minimum Data Set (MDS), dated 3/12/24, indicated R83 was admitted to the facility on 11/17/23, had severe cognitive impairment, was independent with ambulation, and received the following medications during the look back period; antipsychotics and antidepressants. R83's Medical Diagnoses, indicated R83 diagnoses including dementia with behavioral disturbances, major depressive disorder, generalized anxiety. R83's electronic medical record (EMR) lacked evidence of resident specific target behaviors or monitoring for behaviors,	21535	corrected.	

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21535	Continued From page 66 R83's MRR, dated 4/26/24, indicated R83 was receiving the following medications; Seroquel 25 mg three times a day, Mirtazapine 7.5 mg every evening (an antidepressant used to treat depression), and Depakote extended release 125 mg daily and 500mg every evening (an anticonvulsant used to treat seizures and bipolar disorder). The MRR indicated the Seroquel lacked an appropriate diagnosis, indicating dementia with behavioral disturbances but lacked psychotic features of dementia (i.e., hallucinations, paranoia, delusions). The MRR requested a review of whether antipsychotic use was necessary. R83's order for Seroquel, dated 5/14/24, indicated R83 was receiving Seroquel for schizophrenia. R83's EMR lacked documented evidence of provider/prescriber follow up or response on the necessity of antipsychotic use. R83's MRR, dated 5/24/24, indicated to clarify the indication of Seroquel use as it was changed to Schizophrenia and R83 lacked an actual documented diagnosis of Schizophrenia. R83's EMR lacked evidence of a follow up response. During an interview on 6/13/24 at 12:35 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated each director of nursing (DON) had their own process for addressing the MRR's. LPN-D stated the current process was for the DON to send the CP's MRR's to the clinical coordinators via email. If the recommendation was nursing related (i.e., orthostatic blood pressures, target behaviors) the clinical coordinator would address it. If the recommendation was for the provider (i.e., changing medication orders or diagnoses) the	21535		

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21535	Continued From page 67 MRR was put into the provider mailbox for addressing. LPN-D confirmed R83's EMR was missing target behaviors monitoring which is important in monitoring if an antipsychotic medication is effective. CONSULTANT PHARMACIST WAS CALLED TWICE WITH NO RESPONSE During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) stated they were aware the process for MRR's was not working, stating with turnover of the health unit coordinator the MRR forms were ending up in the wrong box leading to MRR follow up being missed. A facility policy titled Psychotropic Medication Use, undated, indicated, "residents will only receive psychotropic medications when necessary to treat specific conditions for which they are indicated and effective" and "the Interdisciplinary team and the primary provider will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for ensuring residents receiving antipsychotic medications have appropriate indications for use and have proper monitoring in place. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21535		

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21610	Continued From page 68	21610		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation and interview, facility failed to ensure mediations were kept locked or under direct observation of authorized staff in areas where residents, staff and visitors could access medications. The deficient practice had the potential to affect 32 current residents on the unit. Findings include: During observation on 6/10/24 at 5:35 p.m., at entrance of the 2S dining room there was an unlocked medication cart. Dining room had 12 residents in the room eating dinner and numerous staff walking past the medication cart transporting residents. During observation and interview with registered nurse (RN)-C on 6/10/24 at 5:36 p.m., RN-C walked up to the unattended medication cart and locked the cart. RN-C stated, "nurses should be sure the med carts are locked and laptop should be closed due to privacy". RN-C stated the nurse responsible for the unattended medication cart was not "in the area" and would try to locate them. During interview with licensed practical nurse (LPN)-B on 6/10/24 at 5:37 p.m., LPN-B stated he	21610	corrected.	7/17/24

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21610	Continued From page 69 was responsible for the unattended medication cart and, "it is a violation. I should lock it [medication cart] when I leave the cart." And, "so no one can get in the medication cart here." During interview with director of nursing (DON) on 6/11/24 at 9:11 a.m., DON stated, "medication carts should always be locked when staff step away from the cart. Because there are some meds in the carts that should not be available to residents." Facility policy on medication storage was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21665	corrected.	7/17/24

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21665	Continued From page 70 review, the facility failed to ensure closet doors in disrepair were reported and acted upon in a timely manner to promote a safe, homelike environment for 1 of 1 resident (R92) reviewed whose closet door was broken with exposed nails present. Findings include: A Vulnerable Adult Maltreatment Report, dated 7/2023, identified a general concern about the care center which included, " ... [it] needs major repairs and there are multiple things that are broken." R92's quarterly Minimum Data Set (MDS)assessment, dated 3/21/24, identified R92 had intact cognition and demonstrated no delusional thinking. On 6/10/24 at 1:46 p.m., R92 was observed lying in bed while in his room. The room had an off-white colored closet with double doors which opened towards the foot of R92's bed. However, the closet door was in disrepair with the door and attached frame being pulled away from the wall several inches exposing multiple construction nails with the bevel-end open to the outside (i.e., room). The door was loose to touch and the closet' interior was visible through the exposed gap between the frame and wall. The closet had visible clothing and CPAP (low pressure air machine used to help breathing) supplies inside. R92 was interviewed and stated the closet was "broken" and had been for "a couple weeks." R92 stated he had asked staff to complete a 'work-order' for it to get it fixed, however, no action had been taken on it yet. R92 stated, "I don't think anybody put in a work order [despite being asked]." R92 stated he wanted it fixed and	21665		

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21665	Continued From page 71 was fearful the door would eventually fall off and onto his bed with him in it. Two days later, on 6/12/24 at 9:02 a.m., the closet door was again observed and remain in disrepair with exposed nails. When interviewed on 6/12/24 at 9:41 a.m., nursing assistant (NA)-D stated R92 needed "100% total" help with cares and was mostly bed-bound. NA-D observed R92's closet door and stated aloud, "It's coming apart!" NA-D stated they were unaware the closet was in disrepair and attempted to move the closet door when it then fell completely off the wall. NA-D stated, "It came out." R92 was present in his bed and again reiterated it had been in such condition "for sure, over a week now." NA-D stated they were unsure if maintenance was aware of it or not and expressed they would get it entered "in TELS [software]" right away to be addressed. On 6/12/24 at 12:33 p.m., the director of maintenance (DOM) was interviewed. DOM explained if staff notice items in disrepair then a TELS work-order should be place so the maintenance staff can be updated about it. DOM stated they had just been made aware of R92's closet door being in disrepair (during the survey) as "nobody put it on there [TELS]." DOM verified none of the staff had completed a TELS and, as a result, nobody from maintenance was aware it was in disrepair adding the closet door "was pulled from the frame itself" and needed multiple staff members to help repair it just prior. DOM stated R92 was mostly bed-bound so it was likely someone else, likely staff, who broke the door adding, "It had to be somebody with quite some force." DOM reiterated it should have been reported to them for repair adding, "I don't know how somebody [would] not notice that." DOM	21665		

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21665	Continued From page 72 added, "It could fall on somebody," and, "It's a safety thing." A Work Order #16293, dated 6/12/24, identified R92's room along with a heading, "Cloet [sic] door broken." A timeline was present which identified the tracking through the TELS system; this outlined it had been created on 6/12/24. There was no further evidence provided to demonstrate the broken closet door had been notified or addressed prior to 6/12/24. A facility' policy on maintenance requests or repairs was not received. Based on observation, interview and document review, the facility failed to promote a dignified environment for 4 or 4 residents (R61, 108, R2, R49). Findings include: R61's Annual Minimum Data Set (MDS) assessment, dated 5/7/24, indicate admission to facility on 11/9/23 and had severe cognitive impairment. In addition, R61 with no impairment of upper and lower extremities, utilized a walker and wheelchair for mobility, and required substantial assistance with toileting and personal hygiene, and dressing. Also, R61 with diagnoses of benign prostatic hyperplasia (enlarge prostate gland making it difficult to empty bladder), polyneuropathy (numbness in extremities), urinary retention, transient ischemic attacks (cerebral stroke affecting brain function), adjustment disorder, and had an indwelling catheter (to drain urine from bladder into a bag). R61's physician orders (PO) dated 11/3/23 included, "Foley Catheter: Please apply leg bag during the day & overnight bag during the	21665		

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21665	Continued From page 73 evening/night". R61's care plan (CP) dated 6/7/23 indicate, "Resident has history of refusing foley catheter leg bag during the day. Has been observed removing the catheter bag cover after it was applied by staff". The CP did not provide interventions to re-approach or offer alternatives to covering the bag when out of his room. During observation on 6/11/24 at 12:45 p.m., R61 sitting on seat of wheeled walker in the main lounge at a dining room table alone. R61's large uncovered catheter bag was hanging on the brake handle of his wheeled walker above the height of his bladder and visible to several staff and residents in the room. The uncovered catheter bag had yellow urine in the tubing and bag. During interview with registered nurse (RN)-A on 6/11/24 at 12:51 p.m., RN-A stated, "not acceptable to have it [catheter bag] above the bladder. It must be below bladder and covered in a bag for dignity and privacy." RN-A stated, "[it is] not ok for catheter to be exposed." During interview with nursing assistant (NA)-A on 6/11/24 at 12:55 p.m., NA-A stated, "the urine bag should be covered in a bag for dignity and its got to be below the waist. Urine should flow in one direction, down. No one wants to see the urine in the bag." During interview with RN-C on 6/11/24, at 2:48 p.m., RN-C stated, "catheter bags should always be covered for dignity. For [R61] it is care planned that we have tried everything to get him to agree to cover it up. He refuses. He gets nasty and we try again. I agree it is not ideal for the other	21665		

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21665	Continued From page 74 residents to have to see his urine. Don't know what else we can do." During observation on 6/12/24 at 7:29 a.m., R61 sitting on seat of wheeled walker in the second floor dining room. Five other residents (R13, R22, R126, R63, and R68) were seated at tables awaiting breakfast. R61 seated across from R13 at the dining room table. R61's urine drainage bag was uncovered and visible to everyone in the dining room including the nursing station adjacent to the dining room. During interview with R13 on 6/12/24 at the same time as observation, R13 stated, "I can't see it from where I am sitting now but I don't really like that thing uncovered. Who wants to see another person's pee[urine]? I would rather not, especially when I am eating or out in the hall or at activities." During interview with R22, R126, R63, and R68 at 7:32 a.m., R22 stated, "Its gross to see that pee in that bag. He don't care but I do. I don't want to see it while I am eating." R126 stated, "Yeah, he [R61] don't care about the rest of us having to see that icky bag" and "[I] wish [R61] would go eat in his room so I don't have to see it. I just sit where I am not facing it." R63 stated, "[R61] always walks around with that bag uncovered." And "[I] wish he didn't because I do not like to eat with that bag visible to me. This is my home too, so I don't think I have to put up with it just because he doesn't want to cover it." R68 stated, "why do we have to see that thing? [R61] don't look at it like we have to. I am about to eat here and I look away. Why is it ok for him to have that thing uncovered so all of us have to look at it? Its not fair". During interview with NA-F on 6/12/24 at 7:45	21665		

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21665	Continued From page 75 a.m., NA-F stated, "[catheter bags] should be covered at all times because of dignity." And "It bothers the other residents but he don't care". During interview with director of nursing (DON) on 6/13/24 at 8:11 a.m., DON stated expectation of all catheter drainage bags to be always covered with privacy bag due to, "dignity". DON stated R61's care plan failed to provide guidance and suggestions for alternatives to his refusal of having a dignity bag to cover his catheter. DON stated there was discussion with the interdisciplinary team regarding his refusals but there was nothing in the medical record to address it. DON stated, R61's CP interventions failed to address re-approaching him or offering alternatives to covering the bag when out of his room. Facility policy on dignity was requested and not received. SUGGESTED METHOD OF CORRECTION: The maintenance personnel, or designee, could make the needed repairs to each identified affected space. In addition, address resident wishes for what they would like to see in their environment. The administrator, or designee, could then review applicable policies and procedures with direct care staff on reporting items in disrepair and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21665		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread	21675		7/17/24

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21675	Continued From page 76 of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to utilize infection control practices while administering medications through gastrostomy tube for 1 of 1 residents (R93) observed for medication administration, utilize infection control practices while delivering meal trays to resident rooms for 7 of 7 residents (R35, R53, R58, R59, R64, R67, R112) observed for dining, while assisting multiple residents to eat at once for 7 of 33 residents (R2, R3, R14,R23, R33, R55, R80) observed for dining. In addition, the facility failed to implement and maintain enhanced barrier precautions (EBP) for 2 of 2 resident (R16, R93) reviewed for transmission based precautions. Furthermore, the facility failed to mitigate transmission of potential infections in relation to laundering of linens and personal items. Findings include: Med Admin R93's quarterly Minimum Data Set (MDS) dated 3/28/24 state admission to facility on 4/6/22, was severely cognitively impaired, and diagnoses of hemiplegia (paralysis) affecting right dominant side, stroke, depression, gastrostomy (feeding	21675	corrected.	

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21675	Continued From page 77 through a tube into the abdomen), and Parkinson's (progressive brain disorder affecting muscle control, balance and movement). R93's physician orders (PO) dated 4/8/22 direct staff to, "Crush each medication in 15ml of warm purified or sterile water and administer each separately using gravity." R93's PO dated 4/22/24 stated, "Before administering medication, stop feeding for 30 minutes and flush the tube with at least 15 milliliters (mL) sterile water." During observation on 6/12/24 at 8:16 a.m., licensed practical nurse (LPN)-A entered R93's room with four medication cups of crushed medications and placed them on his bedside table. LPN-A then obtained the sixty cubic centimeter (cc) piston syringe from his bedside table and added water from a plastic cylinder into each medication cup. LPN-A then paused R93's enteral feeding that was running and removed his abdominal binder to access his GT. LPN-A then auscultated and assessed R93's GT for placement by connecting piston syringe with water in it to R93's GT port and injecting and withdrawing water. LPN-A then disconnected piston syringe from GT port and bent the tubing connected to the resident with her left hand while reaching over to the bedside table and aspirating (withdrawing) medication mixture from one medication cup with her right hand. LPN-A then connected the medication filled piston syringe to the GT port and unbent the GT that was attached to R93. LPN-A then administered medication and bent the GT with left hand and reached over to the bedside table to withdraw another medication. During this process LPN-A allowed the tip of the piston syringe to touch R93's hospital gown several times and used the piston syringe to add more water to the next medication cup. LPN-A	21675		

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21675	Continued From page 78 then withdrew it into the piston syringe and repeated process until all four medications were administered. During administration LPN-A allowed the tip of the piston syringe to touch R93's hospital gown again before adding more water to the piston syringe and flushing the GT port to end the process. LPN-A re-connected enteral feeding tube and re-applied R93's abdominal binder. During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated she had not turned off R93's enteral feeding for thirty minutes prior to administering his medications per PO and, "I should have". Also, "the piston syringe should never touch the resident gown when administering GT meds. Contamination is a concern." During interview with director of nursing (DON) on 6/11/24 at 9:08 a.m., DON stated, "GT feeding tip of piston syringe should not touch gown of resident due to risk of contamination. Staff should [have] replaced it and [sic] get a new one if the end touches anything like the gown of a resident." Facility policy titled Administering Medications through an Enteral Tube updated 3/23/23, "stop the feeding at least 30 minutes prior to medication administration and restart at least 30 minutes after medication administration." And, "Place the end of the tubing on a clean gauze pad positioned on the abdomen or chest of the resident". EBP R16's quarterly MDS dated 4/16/24, stated admission to facility on 12/14/23, had intact cognition, and diagnoses of coronary artery	21675		

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21675	Continued From page 79 disease (CAD), heart failure, peripheral vascular disease, diabetes, depression, and morbid obesity. In addition, 16 at risk for pressure ulcers and had diabetic foot ulcers. R16's physician orders dated 6/11/24 stated, "Wound care: Left Gluteus: Cleanse with wound cleanser. Apply Calmoseptine (ointment). Cover with foam dressing. Every day shift" and "Wound care: Right Gluteus. Cleanse with soap and water. Apply Calmoseptine after peri-care. Every shift". R16's care plan (CP) revised on 5/30/24 stated, "Problem: Resident is currently on Enhanced Barrier Precautions R/T MASD (moisture associated skin damage) on right and left gluteus", and "Problem: Resident is currently on Enhanced Barrier Precautions R/T diabetic ulcer on Left Great toe." During observation and interview on 6/11/24 at 7:12 a.m., R16's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. R16's door and rest of room did not have signage indicating EBP. There was a PPE plastic garbage can with lid on it inside room next to foot of bed. The door was open to the hallway. R16 in electric wheelchair. Two staff members were in the room with a patient lift unit (Hoyer) sling attached to R16 and transfer initiated from wheelchair to bed. Nursing assistant (NA)-D wearing surgical face mask and gloves and no PPE gown. NA-E wearing gloves but no PPE gown. NA-D stated she, "wear [sic] mask sometimes when we go into room. We wear a mask. He [R16] is not on precautions." During observation and interview with registered	21675		

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21675	Continued From page 80 nurse (RN)-B on 6/11/24 at 7:19 a.m., RN-B entered R16 room with gloves and surgical mask but no PPE gown. RN-B assisted with Hoyer transfer of resident to bed. RN-B stated, "[R16] no longer has a wound. Should not be on EBP now." During observation and interview with NA-C on 6/11/24 at 7:33 a.m., NA-C entered R16's room with a surgical mask on and gloves but no PPE gown. NA-C also assisting NA-E, NA-D, and RN-B with direct hands on care for Hoyer transfer from wheelchair to bed. During interview with director of nursing (DON) who is also the infection control preventionist (IC) on 6/11/24 at 8:59 a.m., IC looked in R16's EMR and stated, "Yes, he has a MASD and should be on EBP. Oh wait, it was resolved last week on wound rounds. The nurse manager probably did not remove all of it [signage and PPE equipment]. She should have after the wound rounds." IC stated R16's EMR lacked progress notes or wound care notes indicating R16 was to come off of EBP prior to 6/11/24. IC stated staff wound not be aware of any changes or updates unless there was documentation to support it in the EMR and would expect all staff to follow EBP for R16 until the EMR was updated. R93 R93's care plan (CP) dated 4/3/24 state a focus of, "Problem: Resident is currently on Enhanced Barrier Precautions R/T enteral feeding" with "Interventions/Tasks" of, "-Staff to follow Enhanced Barrier Precautions, -Staff to don/doff PPE (personal protective equipment) per enhanced barrier precautions when providing high contact cares".	21675		

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21675	Continued From page 81 R93's physician orders dated 4/23/24 state, "Resident is currently on Enhanced Barrier Precautions for Enteral Feed every shift". During observation and interview on 6/10/24 at 1:36 p.m., the shared room for R57 and R93's door to hallway had an over-the-door hanger unit with PPE equipment contained in it for PPE gowns and gloves. Signage posted on the door frame stated EBP expectation for staff who care for R93 to wear PPE gown and gloves when providing direct hands on care such as transferring. No PPE garbage can was observed inside or outside R93's room. NA-B exited room without a PPE gown, asking for licensed practical nurse (LPN)-A for assistance with transferring R93 into bed. LPN-A entered room with PPE gown, gloves, and surgical mask. LPN-A stated, R93 on EBP due to, "He had a wound on the side of his knee." NA-B put on a PPE gown from the door unit and then entered R93 room. Both NA-B and LPN-A transferred R93 to bed using the Hoyer. After the transfer was completed, LPN-A exited room with her PPE gown, gloves and mask on and walked down the hall towards the nursing station. LPN-A did not wash her hands prior to exiting the room. NA-B removed gown and gloves and placed the used PPE into a plastic garbage can liner and closed it prior to exiting R93's room. NA-B was unaware of PPE garbage can ever being present in R93's room. During interview with LPN-A on 6/11/24 at 8:42 a.m., LPN-A stated, "the PPE garbage should always [sic] in the [R93] room due to EBP. It was put in there yesterday after you [surveyor] was in here". LPN-A stated, "I should not have walked out of his room with the gown and gloves on when we were transferring him. I should have removed them in the room and put them in a bag	21675		

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21675	Continued From page 82 or something and then sanitized my hands before exiting the room [sic] and re-applied the gown and gloves before going back into his room to help [NA-B] with the Hoyer transfer." During interview with IC on 6/11/24 at 8:59 a.m., IC stated, "staff should not be exiting EBP rooms with face mask, gown and gloves on." IC stated expectation of staff to follow EBP signage instructions to don and doff PPE when working with residents that have EBP signage posted on their doors. Facility policy titled Enhanced Barrier Precautions revised 4/1/24, state, "[EBP] refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi-drug resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)." Further, "Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions" and initiation of EBP for residents with wounds and indwelling medical devices (such as feeding tubes). Also, "Position a trash can inside the resident room for discarding PPE (personal protective equipment) after removal, prior to exit of the room". High -contact resident care activities include, "Dressing, Bathing, Transferring, Providing hygiene, Changing linens, Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and Wound care: any skin opening requiring a dressing." DINING/ HAND HYGIENE: During observation on 6/12/24 at 8:37 a.m., certified nursing assistant (CNA)-O was passing	21675		

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21675	Continued From page 83 out breakfast trays to residents in the third-floor dining room. CNA-O then sat down to assist R2 with eating without performing hand hygiene. During observation on 6/12/24 at 8:45 a.m., CNA-O stopped assisting R2 with eating her breakfast and started assisting R23 with her breakfast without performing hang hygiene in between residents. During observation on 6/12/24 at 8:52 a.m., CNA-J was sitting between R14 and R55, assisting them both with eating their breakfast, switching between each residents' utensils with the same hand. CNA-J did not perform hand hygiene in between. R55 was noted to have a wet, non-productive cough. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and licensed practical nurse (LPN)-D stated the expectation was for the CNAs to perform hand hygiene before assisting residents with eating. During an interview on 6/13/24 at 1:51 p.m., the infection preventionist and director of nursing (DON) stated hand hygiene was expected before and after assisting residents with eating and in between residents if the same hand is being used to assist. R35's annual Minimum Data Set (MDS) dated 5/8/24, indicated R35 had intact cognition and was diagnosed with heart failure, kidney failure, diabetes, and respiratory failure. R53's quarterly MDS dated 2/7/24, indicated R53 had moderately impaired cognition and was diagnosed with diabetes, a stroke, and malnutrition. The MDS indicated that R53	21675		

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21675	Continued From page 84 required a feeding tube and a mechanically altered diet. R53's order summary report dated 4/23/24, indicated R53 was on enhanced barrier precautions "for enteral feed". R58's quarterly MDS dated 3/7/24, indicated R58 had intact cognition and was diagnosed with heart failure, diabetes, and asthma. R59's quarterly MDS dated 3/26/24, indicated R59 had intact cognition and was diagnosed with anemia, depression, and anxiety. The MDS indicated the presence of a surgical wound. R59's order summary report dated 6/10/24, indicated R59 had a wound and was on enhanced barrier precautions. R64's quarterly MDS dated 5/1/24, indicated R64 had intact cognition and was diagnosed with anemia and malnutrition. R67's quarterly MDS dated 3/13/24, indicated R67 had intact cognition and was diagnosed with a leg fracture. R112's quarterly MDS dated 3/28/24, indicated R112 had intact cognition and was diagnosed with kidney disease, diabetes, and hypertension. During an observation on 6/10/24 at 5:54 p.m., nursing assistants (NA)-H and NA-I were observed pushing a tall cart containing meal trays down the hallway toward resident rooms. NA-H was observed to enter R53's room with a meal tray in hand. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table,	21675		

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21675	Continued From page 85 and exiting the room. A sign indicating R53 was on enhanced barrier precautions and "everyone must: clean their hands, including before entering and when leaving the room" was observed on the door. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R58's room tray from the cart and enter R58's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. No hand hygiene upon entering or exiting the room was observed. NA-H was then observed to grab R35's room tray from the cart and enter R35's room. NA-H was observed setting down the tray after adjusting the resident personal items on the bedside table, adjusting the table, and exiting the room. No hand hygiene upon entering or exiting the room was observed. During an observation on 6/10/24 at 6:00 p.m., NA-I was observed to enter R64's room with a meal tray, move personal items on the table, and exit the room. No hand hygiene was observed. NA-I was then observed to grab R67's tray, enter the resident's room, set the tray on the table, and exit. No hand hygiene was observed. NA-I was observed to grab R59's food tray, enter the resident's room, move items on the resident's table, and remove used-looking cup. A sign indicating R59 was on enhanced barrier precautions and "everyone must: clean their hands, including before entering and when leaving the room" was observed on the door. NA-I exited the room, and no hand hygiene was observed. NA-I was observed to grab the meal tray for R112 and enter the resident's room. During an interview on 6/10/24 at 6:03 p.m. with NA-H and NA-I, NA-H stated they were taught to	21675		

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21675	Continued From page 86 complete hand hygiene before starting to pass meal trays and when they are completed with all of the trays but not between individual rooms and NA-I agreed. NA-H and NA-I acknowledged they had not completed hand hygiene before entering and exiting the rooms above including the residents on enhanced barrier precautions. During an interview on 6/13/24 at 1:45 p.m., the director of nursing (DON) stated she expected the NAs to complete hand hygiene before and after a resident room while passing room trays to prevent the possible spread of infection. On 6/12/24 at 8:19 a.m., on 3rd floor dining room in men's care memory unit, it was observed staff assisting resident with breakfast. Nursing assistant (NA)-B alternating between feeding R80, R3 and R33. NA-B was observed using primarily one hand to assist the residents to eat. On 6/12/24 at 10:57 a.m., NA-B verified they were assisting 3 residents at the same time during breakfast today and verified the residents listed above. NA-B stated they wiped down the residents' hands prior to the meal. NA-B stated they did hand hygiene prior to starting to assist the residents with breakfast. NA-B verified they did not perform hand hygiene in between helping residents and used the same hand to feed all 3 residents. NA-B verified residents listed above are dependent on staff for assistance with meals. On 6/13/24 at 11:12 a.m., director of nursing (DON) stated "it's a standard thing" to perform hand hygiene while assisting residents with meals and between residents. DON stated it is important to ensure cross contamination doesn't occur and "they need to clean their hands."	21675		

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21675	Continued From page 87 The CDC article, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, indicates hand hygiene is an important part of stopping the spread of "deadly germs" to residents including those resistant to antibiotics. The article indicates hand hygiene should be completed after touching a resident or their surroundings, after contact with a contaminated surface, and immediately before touching a resident. The facility's Handwashing policy dated 2/24, indicated hand washing should be performed by all employees between tasks and procedures to prevent cross-contamination. F880 - WASH MACHINE During observation of laundry room tour on 6/12/24 at 9:08 a.m., a one-page document was observed hanging on a bulletin board by the entryway door, titled "Any Shift Laundry Routine." The document provided guidelines on what should be done throughout shift indicating the start and end of shift. The start of shift indicated "Load Dryers". At the end of shift, it indicated "Load Washers ....". On 6/12/24 at 9:10 a.m., laundry aide (LA)-A and regional district manager (RDM) present during laundry room tour. LA-A verified they worked full-time in laundry services and were familiar with the job. LA-A and RDM verified the document titled "Any shift laundry routine" was up-to date with expectations. LA-A verified that prior to the end of their shift, they start with wash machines with a load of laundry. LA-A verified the laundry sits in the wash machine through the evening shift and night shift until the next day when staff from the laundry department come in to start their shift. LA-A verified when they start their shift in	21675		

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21675	Continued From page 88 the morning, they take the laundry from the wash machine, that was started at the end of their shift the day prior and put it in the dry machine. On 6/12/24 at 9:13 a.m., RDM verified that she oversees the department and was covering as the manager was out. When asked about leaving laundry in the wash machine overnight, RDM stated, "We are not supposed to do that anymore, we were told that last year." RDM stated she didn't realize it hadn't been updated and would get it corrected. RDM stated leaving wash in the wash machine overnight is of concern "because it could grow bacteria and things on it." On 6/12/24 at 9:38 a.m., administrator stated laundry shouldn't be wet in the wash machine overnight due to "potential bacteria growth". 6/12/24 at 1:43 p.m., RDM stated staff working were provided education regarding not leaving laundry in wash machines overnight, an updated "laundry routine" was hung. RDM stated the remaining laundry staff, and the manager will be in-services upon their return. A facility policy on wet linens/wash machine relating to infection control was requested and not received. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections in relation to laundering of linens and personal items. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are	21675		

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21675	Continued From page 89 being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21675		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote a dignified environment for 3 or 4 residents (108, R2, R49) reviewed. Findings include: R108's quarterly Minimum Data Set (MDS) assessment, dated 5/14/24, indicated R108 had severe cognitive impairment and required partial to moderate assistance with activities of daily living (except eating) and ambulation in the unit hallways. During observation on 6/12/24 at 7:00 a.m., R108 and seven other residents were seated out in the dining room. Four of the residents had coffee in front of them and four had empty juice and coffee	21805	corrected.	7/17/24

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21805	Continued From page 90 cups sitting in front of them. No interaction was observed between staff and residents as staff was still getting residents up for the day. During an interview and observation on 6/12/24 at 7:31 a.m., clinical coordinator and licensed practical nurse (LPN)-D stated breakfast was not served until around 8:30 most days, which was a "long time for these residents to wait." During observation on 6/12/24 at 8:03 a.m., residents were still sitting in the dining area, a total of sixteen residents now, four residents with empty juice and coffee cups in front of them. One resident observed sitting at a table alone, with her forehead resting on the table. During observation on 6/12/24 at 8:10 a.m., there were eighteen residents out in the dining room, juice and coffee at the tables but no food at this time. Outside of the dining room was an empty sitting area with a television, one recliner, one love seat, one side chair and multiple dining room chairs and space for wheelchairs. During an interview on 6/12/24 at 8:12 a.m., certified nursing assistant (CNA)-J stated the process he followed was to get the residents who needed the most care up first and bring them out to sit in the dining room followed by residents who could ambulate on their own. CNA-J stated this order of getting residents up was for convenience to ensure they had enough time to get up all residents up before breakfast. During an interview and observation on 6/12/24 at 8:22 a.m., R108 stated she was still waiting on breakfast (was observed in the dining room since 7:00 a.m.), stating "I am hungry, hopefully soon." The residents in the dining room were becoming	21805		

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21805	Continued From page 91 restless and loud as they were still waiting for breakfast, with residents who were ambulatory getting up and leaving the dining room area. During observation on 6/12/24 at 8:27 a.m., R108 was yelling out, "I am hungry!" from her seat at the table in the dining room. During observation on 6/12/24 at 8:35 a.m., a metal cart with breakfast trays was brought into the dining room and the first residents were served their breakfast. Residents at the same table were not served at the same, with 4 tables having one resident eating and the others at the table without food. Residents who required assistance with eating were served before residents who could feed themselves. All residents were served their food by 8:42 a.m. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and LPN-D stated each CNA had their own process for how and when they would get the residents up each morning. LPN-D stated breakfast used to come up earlier, around 7:30 a.m. - 7:45 a.m., which worked out better for the residents, stating the staff try to "entertain" the residents as best they can while waiting for breakfast. LPN-D stated it gets hard to keep the residents calm in the dining room, stating you can feel the energy change in the room as time goes on and it felt like "we [staff] are just waiting for something to happen." LPN-D stated bringing the residents out to the TV room while waiting for breakfast was not something they had tried before but could try to reduce the institutionalized feel of the breakfast meal. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) stated they had just hired a new dietary manager and were working	21805		

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21805	Continued From page 92 on food times and mealtimes, stating mealtimes used to be earlier. The DON stated the expectation would be to keep the residents engaged while waiting for breakfast either in their room or out in the main TV area. Clothing Labels R108's quarterly Minimum Data Set (MDS) assessment, dated 5/14/24, indicated R108 had severe cognitive impairment and partial to moderate assistance with activities of daily living (except eating) and ambulation in the unit hallways. During observation on 6/10/24 at 4:04 p.m., R108 was sitting in the main dining area, wearing blue slippers with her first and last name visible on the top of her slippers. During observation on 6/11/24 at 2:41 p.m., R108 was sitting in the main dining area, wearing blue slippers with her first and last name visible on the top of her slippers. During observation on 6/12/24 at 7:26 a.m., R108 was sitting in the main dining area, wearing blue slippers with her first and last name visible on the top of her slippers. R2 was also sitting at a table with her first and last name visible on the outside of her slippers. During an interview on 6/12/24 at 2:05 p.m., clinical coordinator and LPN-D stated she was aware clothing labels being visible on the outside of clothing was a dignity concern for residents, confirming the label should not be visible on R2's or R108's slippers.	21805		

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21805	Continued From page 93 During an interview on 6/13/24 at 8:27 a.m., laundry aide (LA)-A stated the process for labeling clothing, including slippers and socks, was to label clothing on the inside of clothing for the safety of the residents. During an interview on 6/13/24 at 1:51 p.m., the director of nursing (DON) confirmed the expectation for labeling clothing was to place all labels on the inside of clothing. R49's quarterly MDS dated 5/15/24, indicated R49 had moderate cognitive impairment and was diagnosed with kidney disease, depression, and a stroke with aphasia (a disorder affecting speech). The MDS indicated R49 was able to independently wheel 50 feet, required set-up help for eating, and was dependent on staff for transfers. R49's care plan dated 4/8/24, indicated R49 enjoyed watching television, visiting the courtyard, and socializing with peers. The care plan indicated staff would assist R49 with activities as needed and encourage and invite R49 to said activities. During an interview on 6/10/24 at 2:29 p.m., family member (FM)-B stated R49 had a stroke and had resulting difficulties with speech but R49 still knew what he wanted and was able to communicate through nodding to yes or no questions. FM-B stated when he came to visit, he would often find R49 sitting in the dining room with no activities going on or a television playing. FM-B stated it bothered him R49 was left there with nothing to do as he knew R49 would not like this. FM-B stated R49 was always an independent person and didn't necessarily like other group activities but had always liked to watch television.	21805		

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21805	Continued From page 94 During an observation on 6/13/24 at 8:24 a.m., R49 was observed sitting at a dining table on the far-right side of the dining room facing the wall. During an observation on 6/13/24 at 8:42 a.m., R49 was observed sitting at a dining table eating breakfast. During an observation on 6/13/24 at 9:06 a.m., R49 was observed sitting at a dining table by himself eating breakfast. During an observation and interview on 6/13/24 at 9:19 a.m., R49 was observed sitting at a dining table by himself and when asked if he was done eating, R49 nodded his head yes. During an observation on 6/13/24 at 9:31 a.m., R49 was observed sitting at a dining table by himself. During an observation on 6/13/24 at 9:49 a.m., R49 was observed sitting at a dining table by himself facing the wall on the right side of the dining room. Three other residents were observed sitting around a table facing and watching television on the left side of the dining room (behind R49). When R49 was asked if he would like to watch television, he nodded his head yes. When asked if anyone had offered to bring him over to the television, he shook his head no. During an observation and interview on 6/13/24 at 9:51 a.m., housekeeper (H)-A was observed sweeping up food debris from the dining room floor. H-A stated she had seen R49 and other residents sitting in the dining room with no entertainment for a long period after meals and	21805		

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21805	Continued From page 95 this had led to residents becoming visibly upset to the point of crying in the past. During an observation on 6/13/24 at 10:07 a.m., R49 was observed sitting at a dining table by himself facing the wall on the right side of the dining room. R49 was observed attempting to push himself away from the table but the right wheel appeared locked so the wheelchair turned to the right but appeared unable to move farther. R49 was then observed to put his head in his hand and look down towards his lap. During an observation on 06/13/24 10:23 AM, RN-E, the nurse manager for the unit, was observed to approach and quickly converse with R49 and was then observed to leave the dining room. During an observation on 6/13/24 at 10:43 a.m., activity staff (A)-B was observed to approach R49 and ask if he wanted to sit by the tv, he nodded yes, and she pushed him in his wheelchair and sat him with the other residents watching television. During an interview on 6/13/24 at 10:48 a.m., RN-E stated she did not think anyone had offered to assist R49 to the other side of the dining room to watch television with the other residents until the occurrence at 10:43 a.m. RN-E stated she would have expected floor staff to offer R49 assistance to the other side of the dining room to watch tv or take him back to his room. During an interview on 6/13/24 at 1:47 p.m., the DON stated she would have expected floor staff to assess what R49's preferences were after a meal, such as returning to his room or participating in other activities. The DON stated	21805		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 96 she would not want R49 stuck sitting alone at his table with nothing to do as it could lead to feelings of sadness. Facility policy on dignity was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to accurately reflect the individual need of each resident discussed above. It could also address other residents that may be at risk for the same concern. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal	21860		7/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00943	A. BUILDING: _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21860	Continued From page 97 interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident records which contained private, medical, and personal information were kept private and not accessible to unauthorized personnel for 1 of 1 residents (R35) reviewed for privacy. Findings include: During observation on 6/10/24 at 5:35 p.m., an unattended medication cart located at entrance of second floor dining room with laptop open to R35 medication list was observed. Dining room had 12 residents in the room eating dinner and numerous staff walking past the medication cart. During observation and interview with registered nurse (RN)-C on 6/10/24 at 5:36 p.m., RN-C walked up to the unattended medication cart and closed the laptop screen. RN-C stated, "nurses should be sure the med carts are locked and laptop should be closed due to privacy". RN-C stated the nurse responsible for the unattended medication cart was not "in the area" and would try to locate them.	21860	corrected.	

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	00943	A. BUILDING: _____ B. WING _____	C 06/13/2024

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21860	Continued From page 98 During interview with licensed practical nurse (LPN)-B on 6/10/24 at 5:37 p.m., LPN-B stated he was responsible for the unattended medication cart and, "it is a violation [to leave the resident medical record visible when walking away from the medication cart]. The laptop should be turned off due to HIPAA [Health Insurance Portability and Accountability Act]. During interview with director of nursing (DON) on 6/11/24 at 9:11 a.m., DON stated, "medication carts should always be locked when staff step away from the cart. The laptop should be turned off [when leaving the med cart]." Facility policy provided to survey team by administrator titled Department of Health Combined Federal and State Bill of Rights for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities, revised 6/18/19 states, "The resident has a right to personal privacy and confidentiality of his or her personal and medical records." SUGGESTED METHOD OF CORRECTION: The DON could inservice staff regarding the importance of confidentiality and privacy of resident information displayed on the computer screen while staff were not present in the area and/or not utilizing the computer screen. An periodic audit could be conducted to ensure compliance and the findings could be communicated to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	**3201 VIRGINIA AVENUE SOUTH** **SAINT LOUIS PARK, MN 55426**

(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 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on June 11, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Estates at St. Louis Park was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 07/08/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/11/2024**

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THE ESTATES AT ST LOUIS PARK LLC	**3201 VIRGINIA AVENUE SOUTH** **SAINT LOUIS PARK, MN 55426**

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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. The Estates at St. Louis Park is a 3-story building with a basement that was constructed at 2 different times. The original building a two story was constructed in 1966 and was determined to be of Type II (222) construction. In 1972 a three-story with a basement addition was constructed to the East Wing and determined to be of Type II (222) construction. The building is fully protected throughout by an automatic fire sprinkler system	K 000		

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	245148	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/11/2024**

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K 000	Continued From page 2 and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 150 beds and had a census of 98 at the time of the survey.	K 000		
K 211 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an egress corridors and emergency egress door per NFPA 101 (2012 edition), Life Safety Code, section 7.1.10.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/11/2024, between 8:30 AM and 11:30 AM, it was revealed by observation that the egress corridor on the 3rd floor by ACU was being obstructed by a chair and table.	K 211	K211 1.Immediate removal of items in the hallway on 6/11/24 that were near the egress doors. 2.Education with all staff on not leaving any items next to or near egress doors will be completed. 3.5 audits will be completed weekly x4 weeks and once weekly for 4 weeks to ensure there are no items near an egress door 4.Audits will be completed by maintenance director or designee	7/17/24

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	245148	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/11/2024**

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K 211	Continued From page 3 An interview with the Maintenance Director and the Administrator in Training verified this deficient finding at the time of discovery.	K 211	5.Date corrected: 7/17	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4	K 222		7/17/24

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K 222	Continued From page 4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain delayed egress locks per NFPA 101 (2012 edition), Life Safety Code sections 19.2.2.2.4(2), 7.2.1.6.1.1(3). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/11/2024, between 8:30 AM and 11:30 AM, it was revealed by observation that the1st floor Ambulance exit door has a 15 second delayed	K 222	K222 1.Signage will be added to all egress doors to state it is an egress and door can be opened in 15 seconds 2.Education with maintenance staff that all egress doors must have proper signage on the door 3.5 audits will be completed weekly x4 weeks and once weekly for 4 weeks to ensure there is proper signage on all egress doors	

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K 222	Continued From page 5 egress device on it. This door did not have the proper signage on it. An interview with the Maintenance Director and the Administrator in Training verified this deficient finding at the time of discovery.	K 222	4.Audits will be completed by maintenance director or designee 5.Date corrected: 7/17	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler	K 353	K353 1.The following items were corrected: 3rd floor med room (AACU) fridge obstructing sprinkler system was removed, 2nd floor break room speaker obstructing the sprinkler head was removed, wheelchair storage room items stored within 18” were	7/17/24

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K 353	Continued From page 6 Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a widespread impact on the residents within the facility. Findings include: On 06/11/2024, between 8:30 AM and 11:30 AM, it was revealed by observation that storage materials we observed being stored within 18" of the sprinkler system in the following areas: a. 3rd floor Med Room (AACU) a fridge was obstructing the sprinkler system b. 2nd floor break room, a speaker was obstructing the sprinkler head c. Wheelchair storage room, items were stored within 18" d. 2nd floor linen room, items were stored within 18" An interview with the Maintenance Director and the Administrator in Training verified these deficient findings at the time of discovery.	K 353	removed, 2nd floor linen room items stored within 18” were removed. 2.Education with all staff on ensuring items are not obstructing or within 18” of sprinkler system will be completed. 3.5 audits will be completed weekly x4 weeks and once weekly for 4 weeks to ensure that no items are stored within 18” of the sprinkler system. 4. Audits will be completed by maintenance director or designee 5. Date corrected: 7/17	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		7/17/24

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K 511	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical boxes in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.1, NFPA 70 (2011 edition), National Electrical Code, section 300.19(C)(2), 314.25, 314.28(C) This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/11/2024, between 8:30 AM and 11:30 AM, it was revealed by observation that at the Main Entrance, there was an electrical cover that had an opening in it exposing high voltage wires. An interview with the Maintenance Director and the Administrator in Training verified this deficient finding at the time of discovery.	K 511	K511 1. The electrical cover that had an opening at the main entrance was closed and corrected. 2. Education with the maintenance staff that all openings in electrical covers must be closed to ensure high voltage wires are not exposed. 3. 5 audits of electrical covers will be completed weekly x4 weeks and once weekly for 4 weeks to ensure there are no openings. 4. Audits will be completed by maintenance director or designee. 5.Date corrected: 7/17	
K 761 SS=B	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.	K 761		7/17/24

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K 761	Continued From page 8 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.4.5, and NFPA 80 (2010 edition), sections 5.2.1. This deficient finding could have an patterned impact on the residents within the facility. Findings include: On 06/11/2024, between 8:30 AM and 11:30 AM, it was revealed by observation that that several of the fire door rating labels had been painted over leaving it unreadable for inspection and verification. An interview with the Maintenance Director and the Administrator in Training verified this deficient finding at the time of discovery.	K 761	K761 1.Removal of paint covering the fire door rating labels for inspection and verification will be completed. 2.Education with maintenance staff on ensuring paint does cover rating labels, ensure that fire door labels can be clearly read for inspection and verification. 3.5 audits of doors will be completed weekly x4 weeks and once weekly for 4 weeks to ensure there is no paint covering labels. 4.Audits will be completed by maintenance director or designee. 5.Date corrected: 7/17	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245148	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING	DATE SURVEY COMPLETE: **6/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	**3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2, 7.2.1.2, 7.2.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/11/2024, between 8:30 AM and 11:30 AM, it was revealed by observation, that there a fire extinguisher in the Kitchen Fan Room that was freestanding and not secured. An interview with the Maintenance Director and the Administrator in Training verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 1, 2024

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: CCN: 245148
Cycle Start Date: June 13, 2024

Dear Administrator:

On July 3, 2024, we notified you a remedy was imposed. On July 23, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 18, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 18, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 3, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 18, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 18, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 1, 2024

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

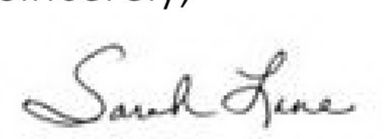
Re: Reinspection Results
Event ID: W6M012

Dear Administrator:

On July 23, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 13, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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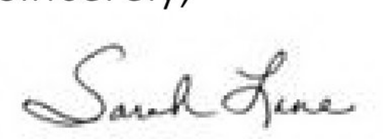

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