CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TVJH

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I	- TO BE COME	PLETED BY T	HE STAT	TE SURVEY AGENCY		Facility ID: 00073
MEDICARE/MEDICAID PROVIDER NO. (L1) 245499 2.STATE VENDOR OR MEDICAID NO. (L2) 190176100		3. NAME AND A (L3) CALEDON (L4) 425 NORTH (L5) CALEDON	IA REHABILIT I BADGER STR	ATION &	RETIREMENT CENTER (L6) 55921	4. TYPE OF ACT 1. Initial 3. Termination 5. Validation 7. On-Site Visit	ON: 2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF O' (L9) 07/01/2018	WNERSHIP	7. PROVIDER/SU	JPPLIER CATEGO 05 HHA	RY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey Aft	
6. DATE OF SURVEY 07/06 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):		X A. In Compli	IS CERTIFIED AS ance With Requirements ace Based On:	S:	And/Or Approved Waivers Of TI2. Technical Personnel3. 24 Hour RN		Services Limit
12.Total Facility Beds 13.Total Certified Beds	49 (L18) 49 (L17)	B. Not in Co	Acceptable POC ompliance with Programd/or Applied Wa		4. 7-Day RN (Rural SN) 5. Life Safety Code * Code: A*		oom Size
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 49	WN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMA	(L39) RKS (IF APPLICABL	(L42) E SHOW LTC CANO	(L43) CELLATION DATE	E):			
17. SURVEYOR SIGNATURE Gail Anderson, Assistant	Program Mana	Date :	07/21/2021	(L19)	18. STATE SURVEY AGENCY Melissa Poepping, Enf		Date: Date:
P	PART II - TO BE	E COMPLETED	BY HCFA RI	` '	L OFFICE OR SINGLE ST	TATE AGENCY	(DZC
DETERMINATION OF ELIGIBILT X	ΓΥ Participate	20. CO	MPLIANCE WITH IGHTS ACT:		21. 1. Statement of Fina	ncial Solvency (HCFA-25 ol Interest Disclosure Stm	
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	24. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION 10/01/1987	BEGINNING	DATE	ENDING DAT	TE .	VOLUNTARY 00 01-Merger, Closure	05-Fail	UNTARY to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATI A. Suspension B. Rescind Sus	n of Admissions:	(L25)		02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	n <u>OTHER</u>	ider Status Change
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
	(L28)	06201		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE			

(L33)

DETERMINATION APPROVAL

04/27/2021

(L32)



Electronically delivered July 21, 2021

CMS Certification Number (CCN): 245499

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 29, 2021 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Flig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117



Electronically delivered July 21, 2021

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

RE: CCN: 245499

Cycle Start Date: February 26, 2021

Dear Administrator:

On March 19, 2021 we notified you a remedy was imposed. On July 6, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 29, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 18, 2021 be discontinued as of June 29, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of March 19, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 18, 2021. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117



Electronically delivered

July 21, 2021

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

Re: Reinspection Results

Event ID: TVJH13

Dear Administrator:

On July 6, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 26, 2021, as well as orders found on the survey completed on June 8, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Paig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117



Electronically delivered June 3, 2021

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

RE: CCN: 245499

Cycle Start Date: February 26, 2021

Dear Administrator:

On March 19, 2021, we informed you of imposed enforcement remedies.

On May 13, 2021, the Minnesota Department(s) of Health and Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

F0655 -- S/S: D -- 483.21(a)(1)-(3) -- Baseline Care Plan

F0684 -- S/S: D -- 483.25 -- Quality Of Care

F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer

F0698 -- S/S: D -- 483.25(I) -- Dialysis

F0758 -- S/S: D -- 483.45(c)(3)(e)(1)-(5) -- Free From Unnec Psychotropic Meds/prn Use

As a result of the revisit findings:

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

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

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

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.

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

As we notified you in our letter of March 19, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 18, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

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

Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 26, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mitter

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

PRINTED: 06/22/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245400	D WING	-		1	R-C
		245499	B. WING			05/	13/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		42	TREET ADDRESS, CITY, STATE, ZIP CODE S NORTH BADGER STREET ALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{E 000}	Initial Comments		{E 00	00}			
{F 000}	compliance with CN Preparedness Req deficient at the time survey exited on 2/compliance with Ap Preparedness Req INITIAL COMMENTON 5/11/21 to 5/13 follow up on deficie standard recertification your facility was NO		{F 00	00}			
{F 655} SS=D	compliance, previo H5499040C (MN56 H5499041C (MN62 The facility is enroll signature is not requage of the CMS-2 correction is require acknowledge receip Baseline Care Plan CFR(s): 483.21(a)(§483.21 Comprehe Planning §483.21(a) Baselin §483.21(a)(1) The implement a baselithat includes the in effective and person	ed in ePOC and therefore a puired at the bottom of the first 567 form. Although no plan of ed, the facility must pt of the electronic documents. 1)-(3) ensive Person-Centered Care e Care Plans facility must develop and ne care plan for each resident structions needed to provide in-centered care of the resident anal standards of quality care.	{F 6	55}			6/29/21
L ARORATORY		DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(X6) DATE

Electronically Signed 06/13/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245499	B. WING		1	R-C / 13/2021	
	PROVIDER OR SUPPLIER	ON & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 425 NORTH BADGER STREET CALEDONIA, MN 55921	.	110/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 655}	(i) Be developed vadmission. (ii) Include the mirnecessary to propincluding, but not lead (A) Initial goals bated (B) Physician orders (D) Therapy services (E) Social services (F) PASARR recording for the comprehensive care plan if the cocial services (i) Is developed wadmission. (ii) Meets the request (b) of this section this section). §483.21(a)(3) The resident and their of the baseline callimited to: (i) The initial goal (ii) A summary of dietary instructions (iii) Any services administered by the on behalf of the facive) Any updated in of the comprehensions REQUIREMED (iii) Based on interviet facility failed to developed vadmission.	within 48 hours of a resident's animum healthcare information erly care for a resident imited to-sed on admission orders. Sees. Sees. Gracility may develop a are plan in place of the baseline emprehensive care planithin 48 hours of the resident's irements set forth in paragraph (excepting paragraph (b)(2)(i) of a facility must provide the representative with a summary re plan that includes but is not as of the resident. The resident is medications and as and treatments to be the facility and personnel acting	{F 65	Immediate action(s) taken for resident(s) found to have beer include:			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
							-C
		245499	B. WING			05/	13/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CALEDO	NIA DELIADII ITATION	N & RETIREMENT CENTER	425 NORTH BADGER STREET		25 NORTH BADGER STREET		
CALEDO	NIA KEHABILITATIO	& RETIREMENT CENTER		C	CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 655}	was admitted to the diagnoses that incluand chronic end state on renal dialysis. R99's hospital disclay 4/30/2021, included hip fracture: weight total hip precaution abduction pillow whas needed. Leave Aseen in orthopedics aquacel dressing we Continue ice and elas possible. R99's Baseline care was not developed hours of admission 4/30/2021, did not ithe care plan direct (4/30/2021)." The owith hospital dischard orders, care plan dias ordered and as the R99's skin care plan not identify the instruplace, and bathing discharge summary did not identify dialy R99's dialysis sche	dated 5/18/2021, identified R99 a facility on 4/30/2021 with uded left femur neck fracture age renal failure dependence are renal failure dependence are summary dated. If the following orders for left abearing as tolerated following as to left lower extremity. Wear alle in bed. Hip wrap to be worn aquacel dressing in place until as. May shower and get the set. No soaking in bathtub, evation to the left leg as much are plan indicated the care plan or implemented within 48 as. The care plan dated include weight bearing status; care staff to "See MD orders are plan was also inconsistent arge instructions and physician rected, "Heat/cold applications colerated (dated 4/30/2021)." In and/or physician orders did fructions to leave dressing in instructions as outlined in the v. The base line care plan also visis emergency procedures, dule and location for dialysis,	{F 6	55}	R99 care plan was updated on 5/3 include weight bearing status, surg dressing and usage of heat and cocompress instructions. Identification of other residents have potential to be affected was accomby: Current resident records audit for the 30 days to ensure that a comprehencare plan was implemented with all required elements of the individual resident needs. Actions taken/systems put into place reduce the risk of future occurrency include: Licensed nursing staff will be refined and process and requirements by June 2021. Licensed nurses starting after 29th, 2021 will be in serviced during orientation on this process. DON/designee will validate in first 2 hours, baseline care plan meeting scheduled. DON/designee will validate 48-hour baseline care plan complete with diagnosis related interventions. How the corrective action(s) will be	ical Id ving the plished he past ensive I ce to e 29th, er June g	
	R99's record lacked	dialysis access site. d evidence of a physicians heat and also lacked			monitored to ensure the practice w recur: DON or designee will audit care pla		
	oraci ioi tile use oi	neat and also lacked			DON OF GESTATION WILL AUGIL CALE DIS	ai io	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245499	B. WING				-C
NAME OF F	PROVIDER OR SUPPLIER	240400	5: ::::::0		REET ADDRESS, CITY, STATE, ZIP CODE	U5/	13/2021
CALEDO	NIA REHABILITATION	N & RETIREMENT CENTER		425 NORTH BADGER STREET CALEDONIA, MN 55921			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 655}	1 3		{F 65	55}	Out we also for an arrange that he are discounts	£	
		er to discontinue the hip wrap e assessment that determined eeded.			2x/week for one month then 1 x wk two months. Results of finding will k reviewed in QAPI monthly to validate compliance after 3 months.	ре	
	director of nursing (plan and confirmed of hip surgery interv hospital discharge s dialysis intervention	on 5/12/21, at 4:07 p.m. (DON) reviewed R99's care the care plan lacked aftercare ventions outlined in the summary and also lacked as. DON indicated an e interventions be identified in lan.			Corrective action completion date:June 29th -2021		
	that the resident's in and maintained, a be developed within 48 admission. The inter the healthcare prace a baseline care plan care needs including based on admission	I 12/2016 included, To assure mmediate care needs are met paseline care plan will be 3 hours of resident's erdisciplinary team will review tioner's orders and implement in to meet resident's immediate go but not limited to initial goals in orders, physician orders, apy services, social services.	{F 68	34}			6/29/21
	applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro practice, the compr care plan, and the r This REQUIREMEN by:	fundamental principle that then and care provided to based on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of the ensive person-centered residents' choices. NT is not met as evidenced					
	Based on documer	nt review and interview the			1. Immediate action(s) taken for th	е	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
			A. BUILD		R-	C	
		245499	B. WING			3/2021	
NAME OF PF	OVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE	·	0,202.	
OAL EDON	LA DELLADULTATIO	ON & DETIDEMENT OFNED		425 NORTH BADGER STREET	Г		
CALEDON	IA KEHABILITATI	ON & RETIREMENT CENTER		CALEDONIA, MN 55921			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
	for the monitoring dressings for surgand signs and syntemain in place for R101). In additionand evaluate the effectiveness of produced by the	nsure appropriate documentation and evaluation of occlusive gical site for dressing integrity inptoms of infection that were to or 2 of 2 residents (R99 and in, the facility failed to document extent of edema and obysician ordered treatments for lagement for 1 of 3 residents intation of edema and physician illance and management. It dated 5/18/2021, included etes type II, hypertensive chronic pendence on renal dialysis, and behavioral disturbance. In scharge summary dated ited discharge diagnosis of left instructed to leave the left hip in place until seen in your provider if foul drainage and wound fredness.	{F 68	resident(s) found to hat include: R99 had an order for nevaluation q shift of the signs and symptoms of integrity of dressing sitted EMAR on5/18 R101had an order for nevaluation q shift of the signs and symptoms of integrity of dressing sitted EMAR on5/18 R100 had an order for effectiveness of physical treatment for edema of EMAR on5/18 2. Identification of othe the potential to be affect accomplished by: Facility reviewed curre surgical dressing to valorders placed in EMAF. Facility reviewed curre prescribed physician treatment to validate placed in EMAR. 16 Id. 3. Actions taken/syster.	monitoring and e surgical site for finfection and e placed on the monitoring and e surgical site for finfection and e placed on the monitoring for sians prescribed nanagement on the er residents having cted was nt residents with a lidate monitoring R. None identified. In tresidents with a featment for edema te monitoring orders entified.		
i	abnormalities, fail nfection, macera R99's record lack	nt of skin injury. Report lure to heal, signs/symptoms of tion etc to the MD. ed evidence the surgical site r signs and symptoms of		Actions taken/syster reduce the risk of futur include: Licensed nursing staff on monitoring and evaluations.	e occurrence will be in serviced		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING			R- 05/1	-C 13/2021
	PROVIDER OR SUPPLIE	ON & RETIREMENT CENTER		STREET ADDRESS 425 NORTH BAD CALEDONIA, N		1 00,	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	IDER'S PLAN OF CORRECTION SHOULE CORRECTIVE ACTION SHOULE EFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 684}	infection and lack dressing was more R99's Initial Would Identified R99 had incision and "aquituntil follow-up ortifurther assessments skin or dressing in R99's record identified skin interested completed of 5/11/21; the summing area of the resident had record lacked eviture were completed. During an intervien unawareness of wintegrity was bein skin around the dredness/swelling checked for any cat least daily. R101 R101's Face She was admitted to the diagnoses that in Alzheimer's disease R101's Hospital of 5/3/21, identified fracture and instruction.	ed evidence the integrity of the nitored. Ind Assessment dated 4/30/21, da rear left thigh surgical accel dressing to be left in place no. Wound not assessed." No int/description of the surrounding integrity. It filed Daily Skilled Summary's on 4/30, 5/1 5/6, 5/8, 5/10, and maries identified R99 had agrity of "incision", the summary inpletion of a wound assessment in impairments to skin. R99's impairments to skin. R99's dence wound assessments It won 5/12/21, director of viewed the records, indicated an where the incisions and dressing gournented and indicated the ressing should be checked for and the dressing should be drainage and remained in place are dated 5/3/21, identified R101 in facility on 5/3/21 with cluded left hip fracture and	{F 6	surgical site infection and documentar physicians pedema mar Licensed N will be in set this process DON/Design EMAR or mornings of the trecur: DON or descompliance x wk for two be reviewed compliance.	gnee will monitor for on orders during the following linical meeting. corrective action(s) with the ensure the practice of the ensure will audit for ME action and the ensure the practice of the ensure the ensure that the ensu	site and f or 2021. 29-2021 on on nissions ng II be will not OS th then 1 nding will alidate	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245499	B. WING				-C 13/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET ALEDONIA, MN 55921	1 03/	13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 684}	smelling/pus-like dr swelling/bleeding/re R101's physician of dressing in place un shower and get dre dressing continue in much as possible. R101's care plan da identification of the surgical incision or incision. The care actual impairment to [sentence was not of R101's record lacked surgical site for inter for signs and sympol R101's Admit/Read identified the left hip details/comment set fracture-surgical dreating or ortho follow-up. The and/or address the description of surror R101's Daily Skilled included a section ' areas, cuts, lacerate abrasions- respons complete wound as resident had any was urgical wound was	rainage and wound edness. rders included, Leave aquacel ntil seen in orthopedics. May essing wet; do not soak ce and elevation to left leg as ated 5/3/21 lacked presence of the left hip care and treatment of the plan included, "I have potential o skin integrity related to completed]. ed ongoing monitoring of the egrity of occlusive dressing and toms of infection. mit assessment dated 5/3/21, p surgical incision. The ection included: Left hip essing to be left in place until e assessment did not include integrity of the dressing or a funding skin. d Summary's dated 5/4/2021, "Skin Conditions". 2a. Open ions, skin tears, and e was "Yes-describe and seessment" 4a. read if the bounds- the response was "no";	{F 6	84}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SUR\ COMPLETE	
		245499	B. WING			R-C / 13/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP OF 425 NORTH BADGER STREET CALEDONIA, MN 55921		113/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
{F 684}	R101's Daily Skille indicated R101 did or surgical wounds R101's Daily Skille indicated R101 had incision, R101's reassessment as directed R101 had have surgical wound evidence of wound R101's Daily Skille indicated R101 had description of "incitof wound assessment R101's Daily Skille indicated R101 had description of "incitof wound assessment R101's Daily Skille 5/10, indicated R101's Daily Skille indicated R101's Daily Skille indicated R101's Daily Skille indicated R101's Daily Skille indicated R101 did	d Summary dated 5/5/21, not have any skin impairments is. d Summary dated 5/6/21, d skin impairment of surgical cord lacked evidence of wound ected by the summary. d Summary dated 5/7/21, d skin impairment and did not nds. R101's record lacked l assessment. d Summary dated 5/8/21, d skin impairment with sion"; record lacked evidence	{F 68	,		
	R100's physician c -Tubigrips on in the	cellulitis of left lower limb.				
	-2 gram sodium di	et (start date 4/28/21) by mouth two times a day for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245499	B. WING				-C
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STF 425	REET ADDRESS, CITY, STATE, ZIP CODE NORTH BADGER STREET LEDONIA, MN 55921	<u> U5/</u>	13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 684}	heart failure with prediction of the dema, weight of the w	eserved ejection fraction and any by mouth two times a day gain for 2 days and give 50 mg for edema (order start date). The location and a was not identified. eserved ejection fraction and give 50 mg for edema (order start date). The location and a was not identified. The location and or evaluation of g. ema bilateral ema bilateral ema bilateral ema bilateral ema bilateral.	{F 6	34}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245499	B. WING			R-C / 13/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP 425 NORTH BADGER STREET CALEDONIA, MN 55921	•	13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 684}	-5/2/21- pedal eden No assessments ev -5/6/21-pedal edem -No assessment ev -5/8/21-pedal edem -No assessment ev -5/12/21- in the skir for edema; the sect describe in the card the cardiovascular s -5/13/21- pedal ede During an interview director of nursing i assessed, document changes. Facility policy Press Breakdown-Clinical included The nurse shall des the following: Full a including location, s depth, presence of Current treatments, The staff will exami admission for ulcera	na bilateral vident on 5/3, 5/4, 5/5/2021 a bilateral ident on 5/7/21 a unilateral ident on 5/9 or 5/10/21. In section the box was checked ion gave the direction to liovascular section however, section was left blank. Ima unilateral on 5/13/21, at 2:20 p.m. Indicated edema should be inted, and monitored for sure Ulcers/Skin Protocol dated 4/2018 cribe and document report is sessment of pressure sore size, stage, length, width, and exudates or necrotic tissue. Including support surfaces including support surfaces including or alterations in skin.	{F 68	34}		
•	provided. Treatment/Svcs to I CFR(s): 483.25(b)({F 68	36}		6/29/21
	§483.25(b) Skin Into §483.25(b)(1) Press Based on the comp					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245499	B. WING			-C 13/2021
NAME OF	PROVIDER OR SUPPLIEI	₹	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		10/2021
				425 NORTH BADGER STREET		
CALEDO	NIA REHABILITATIO	ON & RETIREMENT CENTER		CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION COROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 686}	resident, the facilii (i) A resident rece professional stand pressure ulcers at ulcers unless the demonstrates that (ii) A resident with necessary treatment with professional promote healing, new ulcers from control of the promote healing, new ulcers from the promote of the p	ty must ensure that- ives care, consistent with dards of practice, to prevent and does not develop pressure individual's clinical condition to they were unavoidable; and pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent leveloping. ENT is not met as evidenced ent review and interview the implete comprehensive sessments for 1 of 1 residents for pressure ulcers. It dated 5/18/2021, identified end to the facility on 4/26/21 with cluded congestive heart failure, edema, cellulitis of left lower obstructive pulmonary disease. Minimum Data Set (MDS) d 5/4/21, indicated R100 did not pairment, did not have if care behaviors. The MDS quired extensive assistance staff for bed mobility and we assist from one staff for toilet hygiene. MDS indicated R100 incontinent of bowel and entified R100 had 4 stage II of them were present upon	{F 68	1. Immediate action(s) taken resident(s) found to have beinclude: R100 Pressure Ulcer risk fact and added to the Care Plan Comprehensive Skin Assess completed 6/22/21. 2. Identification of other resid the potential to be affected waccomplished by: Current resident with pressureviewed for an accurate ME Care Planning. All other resirisk. Facility review completed to current resident have a scheskin evaluation completed. 3. Actions taken/systems professional to reduce the risk of future of include: The facility will implement by 2021, daily wound monitoring.	en affected ctors identified on 6/18. sment ents having //as re ulcers //S, CAA and idents are at validate that duled weekly out into place ccurrence // June 29th, g tool that	
	use and personal was occasionally bladder. MDS ide pressure ulcers, 2	hygiene. MDS indicated R100 incontinent of bowel and entified R100 had 4 stage II to fithem were present upon		to reduce the risk of future of include: The facility will implement by	June 29th, g tool that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245499	B. WING			R-C 05/13/2021	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP (10/2021	
				425 NORTH BADGER STREET			
CALEDONIA REHABILITATION & RETIREMENT CENTER			CALEDONIA, MN 55921				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
{F 686}	R100's pressure ul (CAA) was incomp The assessment in information: "I have skin integrity r/t preposterior knee, left associated skin da R100's skin integritincluded "I have poskin integrity r/t [rel posterior knee, left Interventions included "I have posterior knee, left Inter	cer Care Area Assessment lete and questions left blank. Included the following a potential/actual impairment to essure ulcers bilateral knee, left toes. MASD[moisture mage] to butt" Ity care plan dated 4/27/21 otential/actual impairment to lated to] bilateral knee, left toes. MASD to butt." Ided Monitor/document location, of skin injury. Report re to heal, signs and tion, maceration etc. to ided. Ided Word assessment was completed upon tion, the record lacked or comprehensive assessments deterioration of the wounds int, and appropriate treatment ventions. Wound assessment dated delocation and measurements delacked a comprehensive wounds. Interval a comprehensive wounds in the comprehensive wounds. Interval a comprehensive wound pressure, a cm (centimeters) x 0.4 cm x cer was not identified.	{F 686	following: dressing, drainag skin color and integrity, and Comprehensive skin asses done quarterly, annually, ar changes. Facilities Unit Manger will be on completing comprehens assessments to include prenon-pressure related skin it concerns. Facility has a full experienced MDS nurse standard education completed urorientation. Licensed Nurses will be in some June 29th -2021on completed resident is weekly skin evalued electronic health record. Indeducation will be the new domonitoring tool for all resided currently have skin concernations be in serviced duron this process. DON/Designee will validate admissions with pressure usection M of the MDS, CAA completed. 4. How the corrective actimonitored to ensure the prarecur:	d pain. sments will be and with sig be reeducated give weekly skin essure and entegrity time arting on June arting on June arting on the cluded in aily skin wound ents who as. Facility r June 29th aring orientation and Care Plan on(s) will be actice will not		
	measurements 5.5 of ulcer was not ide -Left knee (rear), ty	/pe of wound pressure, cm x 4.2 cm x 0.1 cm; stage		DON/Designee will audit re 2x/week for one month thei two months for appropriate of weekly skin evaluation at DON/Designee will audit re	n 1 x wk for documentation nd care plans.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING				-C 13/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		S1 42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET ALEDONIA, MN 55921	1 03/	13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 686}	-Left toe, type of wo 1.1 x 1.0 (box for downs not identified.) -Left toe, type of wo 0.7 x 0.7 x 0.1. State R100's Initial Wound identified an addition left lateral thigh that 01. cm. The assess 100% epithelization with no drainage. Protection identified. R100's Initial Wound 4/26/2021, identified thigh that was staged cm x 0.1 cm; 25% of 75% granulation. Protection identified hower factors identified and trochanter that mean cm, and 100% of the slough with a small [pale/transparent] diseparate section the serosanguinous [yes R100's weekly skin included the wound not comprehensive were not identified as a stage 5.4 cm x 01. Cm. In Comments/recomn "Left trochanter meepithelialization, 50"	bund pressure, measurements epth left blank); stage of ulcer bund pressure, measurements ge of ulcer was not identified. In Assessment dated 4/26/21 and pressure ulcer to R100's to measured 1.6 cm x 1.4 cm x sment indicated the wound had approcess in wound healing] bressure ulcer risk factors were and Assessment dated diadditional ulcer on left rearge II. Measured 8.5 cm x 4.7 for the wound was eschar with redisposing risk factors were wer in the comment box for risk nother wound to R100's left assured 1.7 cm x 2.6 cm x 0.1 fine wound was covered with amount of serous rainage. However, in a fedrainage was identified as sellow with blood] drainage. In assessment on 5/5/2021, the however each wound was allow with blood] drainage. It is however each wound was ally assessed; Stage of ulcers except for the left rear thigh; the 2 and measured 4.4 cm x in section F. Other 1. Other mendations included: the assures 1.9 x 2x 0.1 cm 50%	{F 68	36}	daily wound monitoring tool 2x/wee one month then 1x/week for two monthly and compliance validated months. Corrective action completion da	onths. in QAPI after 3	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245499	B. WING		R-C 05/13/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 686} {F 698} SS=D	epithelialization. Left great toe callosecond toe 0.1 x 0 [signs/symptoms] the areas were he anterior knee and since the last asses R100's Weekly Sk identified a right kneasured 6.2 cm staged. The assessimproved however assessments for the Facility policy Pressure depth, presence of Current treatments. The staff and pracent treatments and pracent treatments of the staff will example admission for ulced Dialysis CFR(s): 483.25(l) Dialysis The facility must erequire dialysis recondernation of the staff staff staff staff staff staff staff staff will example and staff will example staff staff will example staff sta	sus 1.9 c 1.6 cm .9 cm scabbed Left. No s/sx of infection." The note indicated aling appropriately however, left toe ulcers had increased in size essment. in Assessment dated 5/5/2021 nee pressure ulcer that by 5.0 cm. The ulcer was not sment indicated the wound had there was no previous ne right knee. sure Ulcers/Skin al Protocol dated 4/2018 escribe and document report assessment of pressure sore size, stage, length, width, and f exudates or necrotic tissue. s, including support surfaces. 3. tioner will examine the skin of sidents for evidence of existing other skin conditions. hine the skin of a new rations or alterations in skin.	{F 68			6/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245499	B. WING_			-C 13/2021	
	PROVIDER OR SUPPLIER	ON & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP (425 NORTH BADGER STREET CALEDONIA, MN 55921	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{F 698}	This REQUIREME by: Based on intervie facility failed to de emergency proced dialysis access sit addition, failed to dialysis clinic and restrictions as ord residents (R99, R. Findings include R99's Face Sheet diagnosis of diabe renal disease, dep dementia without R99's hospital dis identified R99 had internal jugular, id dialysis center, an R99's baseline ca 5/3/21, the care pi procedures, locati schedule. The car signs and sympto access site locate care plan also dire peripheral edema R99's record lacke site was monitore infection.	ew and document review the velop a dialysis care plan with dures, failed to monitor a refor 1 of 3 residents (R99). In rensure coordination of care with failed to evaluate daily fluid rered by the physician for 2 of 3 (23) reviewed for dialysis. Adated 5/18/2021, included retes type II, hypertensive chronic rendence on renal dialysis, and behavioral disturbance. Charge summary dated 4/30/21, in a hemodialysis catheter in right rentified the location of the right dialysis schedule. The plan was not developed until and did not identify emergency on of dialysis center, or dialysis re plan instructed to monitor forms of infection of the dialysis don the right subclavian. The rected to monitor/document and monitor intake and output. The red evidence the dialysis access do for signs and symptoms of red evidence of coordination of red evidence of coordi	{F 69	Immediate action(s) taken resident(s) found to have be include: R99 Dialysis Care Plan to it emergency procedures, loc Dialysis Center and Dialysis was initiated on5/31	nclude cation of s Schedule the EMAR to shift on _5/17 the EMAR to shift on the EMAR to shift on the EMAR to shift on the Licensed site for signs s, fluid intake, n with dialysis esidents having was eviewed current alysis Care procedures, and Dialysis aluation qshift put into place occurrence serviced on sident		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, 50120			R-	-C
		245499	B. WING			05/	13/2021
NAME OF	PROVIDER OR SUPPLIE	R		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CALEDO	NIA DEHARII ITATI	ON & RETIREMENT CENTER		42	5 NORTH BADGER STREET		
CALLDO	MIAINLIIADILIIAII	ON & RETIREMENT CENTER		CA	ALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 698}	R99's physician of 1500 cc's [cubic of 660 cc Dietary= 8 Evening Shift give Please document 4/30/21.) R99's fluid intake 5/11/21. The reco 24-hour totals of 124-hour fluid intake per shift were cor amounts and the assessments for 5/1- day shift intake, 120 cc,	riders included: Fluid restriction - centimeters] per day. Nursing= 240 cc. Day Shift give 820cc, 2680cc, Night Shift give none. 26CTUAL fluid intake (start date) was reviewed from 5/1 to 3rd did not reflect calculated fluid intake or an evaluation of 3rd sistently under allotted daily 3record lacked evidence of 3rd dehydration. 3rd was 120 cc, evening shift 3rd shift 0 3rd, 40 cc. 3rd, 0 cc 3rd, 120 cc 3rd, 1	{F 6	98}	required upon admission on the b care plan with updates with any chand new dehydration evaluation of June 29th -2021. Licensed nurse accesses every shor signs of infection, routine weigh intake, and routine communication dialysis center. Licensed Nurse hired after June -2021 will be in serviced during or on this process. DON/Designee will validate in the morning clinical meeting that the Emergency Procedures are in plance Dialysis communication form is fill in its entirety. 4. How the corrective action(s) when morning clinical meeting that the form the form two months for validation of appropriate Dehydration evaluation documentation. Results of finding will be reviewed monthly and compliance validated months. Corrective action completion of June 29th , 2021	nanges rder by hift site hts, fluid n with 29th ientation next Dialysis ce and led out vill be will not AR en 1 x wk n in QAPI I after 3	
	weight monitoring	for evaluation of fluid overload.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R-C	
		245499	B. WING				13/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		425	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH BADGER STREET LEDONIA, MN 55921	1 00.	10,2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 698}	admission to the fa -4/30 weight (wt.) 1 -5/1 wt. 144.6 lbs5/2 wt. 142.2 lbs5/3 wt. 143.0 lbs5/4 wt. 143.0 lbs5/6 wt. 143.4 The record did not after 5/6/21. R23 R23's Face Sheet of diagnoses of chrondependence on rerestance on the second dependence on rerestance of the second dependence of the second dependence of the second dependence of the second depe	fied weight increases since cility. 40.4 pounds (lbs.) identify weight were recorded dated 5/18/21, included ic kidney disease, and dialysis, and diabetes type ders included, 200 cc's per day. Nursing=Day Shift give 660 cc, Evening ight Shift give none. Please and intake (order start date day, Thursday, Saturday (start to 0.5 milligrams- 1 tablet by the gevery Monday, Wednesday, a related to end stage renal deplan dated 3/1/2021 cian order for 1100 cc fluid erventions included, Break then nursing and dietary to uid intake and encourage	{F 6	98}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING				-C 13/2021
	NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER				T ADDRESS, CITY, STATE, ZIP CODE ORTH BADGER STREET DONIA, MN 55921	1 001	13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 698}	intakes recorded or Administration Recobetween 5/1 and 5/were below (fluid de amounts. The recomonitored and asset to the daily fluid def 5/1- day shift 60 cc's hift 30 cc's 5/2- 30 cc's, 120 cc's 5/2- 30 cc's, 120 cc's 5/3- 60 cc's, 120 cc's 5/5- 100 cc's, 120 cc's 5/6- 100 cc's, 120 cc's 7/6- 120 cc's, 180 cc's, 120 cc's,	the Medication ord (MAR) were reviewed 11/21; the intake amounts efficit) the allotted shift ord lacked evidence R23 was essed for dehydration related ficits. Is, and cc's set, and cc		98}			

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245499	B. WING			R-C / 13/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (425 NORTH BADGER STREET CALEDONIA, MN 55921		713/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
{F 698}	addition, R23's received and the total fluid intake to Administration Retotal fluid intake for an average of 3 lacked evidence the further evaluation gains in the abserventriction. R23's record lacked was transcribed in and/or care plan. Review of R23's weight was weight gains; 3/17/21- 220 lbs. 4/9/21- 217.8 lbs. 4/23/21-218.2 lbs. During and intervidurector of nursing out per shift, nurse administration receive give additional fluority would be evaluated that shift according shift; at shift reporcommunicated to unawareness how evaluated. DON reconfirmed R99's weigh the total shift according shift; at shift reporcommunicated to unawareness how evaluated. DON reconfirmed R99's weight dialysis confirmed R99's weight gains; at shift reporcommunicated to unawareness how evaluated. DON reconfirmed R99's weight gains; at shift reporcommunicated to unawareness how evaluated. DON reconfirmed R99's weight gains; at shift reporcommunicated to unawareness how evaluated. DON reconfirmed R99's weight gains; at shift reporcommunicated to unawareness how evaluated. DON reconfirmed R99's weight gains; at shift reporcommunicated to unawareness how evaluated. DON reconfirmed R99's weight gains; at shift reporcommunicated to unawareness how evaluated. DON reconfirmed R99's weight gains; at shift reporcommunicated to unawareness how evaluated. DON reconfirmed R99's weight gains; at shift reporcommunicated to unawareness how evaluated.	ges for not giving extra fluid. In cord did not identify fluid intakes and 4/21/21 exceeded R23's on of 1200 cc's daily. The tal on the Medication cord (MAR) identified R23's or those 7 days was 2,150 cc's into 7 cc's daily. The record ne dialysis clinic was notified for and management of weight one of not following the fluid ed evidence the dialysis order to the facility's physician orders weight record did not identify consistently monitored for fluid es document on the medication ord, and aides were not allowed fluids. DON indicated fluid d for the amount consumed g to what was allotted on that the deficits/overages would be the next shift. DON indicated and the 24 hour daily totals were eviewed R99's record and was lacking and record lacked onitoring for signs/symptoms of o confirmed R99's record mmunication forms. DON stated as supposed to be completed by	{F 69	8}		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	COMPLETED	
		245499	B. WING			R-C 05/13/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZII 425 NORTH BADGER STREET CALEDONIA, MN 55921	P CODE	33,10,2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIA		
{F 698}	the dialysis nurse a completed. DON st notebook back and	and verified the forms were not ated dialysis residents bring a forth, and if there was a notebook expected staff to ecord.	{F 6	98}			
	Free from Unnec P CFR(s): 483.45(c)(3) \$483.45(e) Psychology 8483.45(c)(3) A psy affects brain activiti processes and behavious are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compreresident, the facility §483.45(e)(1) Residus psychotropic drugs unless the medicati	sychotropic Meds/PRN Use 3)(e)(1)-(5) cropic Drugs. chotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following chensive assessment of a must ensure that dents who have not used are not given these drugs on is necessary to treat a s diagnosed and documented	{F 7	58}		6/29/21	
	drugs receive gradu behavioral intervent contraindicated, in a drugs; §483.45(e)(3) Resid	dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	psychotropic drugs	pursuant to a PRN order					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		(X3) DATE SURVEY COMPLETED	
245499		B. WING		R-C 05/13/2021	
	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	00/10/2021	
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLÉTION	
unless that medical diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 da §483.45(e)(5), if the prescribing practitic appropriate for the beyond 14 days, he rationale in the resi indicate the duratio §483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practitic the appropriateness. This REQUIREMED by: Based on interview facility failed to ensity justification for off labenzodiazepine for develop/implement non-pharmacologic of 1 resident (R13) psychotropic medic Findings include: R13's Face Sheet of diagnosis of end state dependence on rencoordination, and un According to the diagnosis to the diagnosis of the diagno	tion is necessary to treat a condition that is documented d; and orders for psychotropic drugs ys. Except as provided in a attending physician or oner believes that it is PRN order to be extended or she should document their dent's medical record and in for the PRN order. orders for anti-psychotic 14 days and cannot be a attending physician or oner evaluates the resident for so of that medication. NT is not met as evidenced or and document review the ue appropriate diagnosis and abeled use of a sleep and failed to individualized al interventions for sleep for 1 reviewed for unnecessary eations.	{F 758	1. Immediate action(s) taken for the resident(s) found to have been affer include: R13 Care Plan was updated on 5/1 include non-pharmacological intervation promote sleep. Sleep log initiated and completed or reflect residents sleep pattern. Sleep evaluation completed 6/9/21 reviewed by R13 provider. Will requisive sleep study to be completed. 2. Identification of other residents the potential to be affected was accomplished by: Facility currently has no other residents taking psychotropic medication for	8_ to entions aily to and to uest having ents on sleep.	
R13's physician ord	lers included the following:				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTE PROBLEM CONTINUED FROM PARTICIPATION OF LETTE PROBLEM PARTICIPATION OF LETTE PARTICIPATI	PROVIDER OR SUPPLIER NIA REHABILITATION & RETIREMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 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 ensue appropriate diagnosis and justification for off labeled use of a benzodiazepine for sleep and failed to develop/implement individualized non-pharmacological interventions for sleep for 1 of 1 resident (R13) reviewed for unnecessary psychotropic medications.	PROVIDER OR SUPPLIER NIA REHABILITATION & RETIREMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 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 ensue appropriate diagnosis and justification for off labeled use of a benzodiazepine for sleep and failed to develop/implement individualized non-pharmacological interventions for sleep for 1 of 1 resident (R13) reviewed for unnecessary psychotropic medications. Findings include: R13's Face Sheet dated 5/18/2021, included diagnosis of end stage renal disease, dependence on renal dialysis, lack of coordination, and unsteadiness on feet. According to the diagnosis listing, R13 did not have a diagnosis of insomnia or anxiety.	ROVIDER OR SUPPLIER NIA REHABILITATION & RETIREMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) (REACH DEFICIENCY WILLS THE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 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. \$483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 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 propriate diagnosis of that medication. This REQUIREMENT is not met as evidenced by: B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921 FROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE CROSS	

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′			(X3) DATE SURVEY COMPLETED	
	245499	B WING				
		B. WING	0.T.D.E.T.A.D.D.E.O.O. O.T.V. O.T.A.T.E. 71D.O.	•	13/2021	
PROVIDER OR SUPPLIE	ĸ			ODE		
NIA REHABILITATI	ON & RETIREMENT CENTER					
			CALEDONIA, MN 55921			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFI) TAG	((EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
-Lorazepam (ben at bedtime for ins	zodiazepine) 0.5 mg (milligrams) omnia (start date 4/19/2021).	{F 75	include:	erviced on the		
- Trazodone (antidepressant) 100 mg at bedtime for sleep (start date 4/22/2020)Mirtazapine (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) R13's care plan copied from R13's record on 5/11/2021 indicated the care plan had not been revised since 11/30/2020. The care plan included; "The resident uses antidepressant medication Trazodone r/t [related to insomnia" (dated 9/13/2019). The care plan indicated the goal of the medication was "The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. The care plan lacked a goal associated with improving sleep. Interventions included: Monitor/document/report as needed adverse reactions to antidepressant therapy.			non-pharmacological intervented with the resident medication by June 29 -202	entions routine sleep 1. Licensed		
			serviced during orientation of process. DON/Designee will validate admissions receiving sleep have a sleep log initiated during morning clinical meeting and pharmacological intervention planned. Sleep assessments to be condition. DON/Designee will validate quarterly, annual, and signif	new / re medication uring the next d non- ns are care completed on nd with change during icant change		
individualized nor interventions. R13's Sleep Eval incomplete. Questincluded; diagnosthow long it takes many times the result with the result will be a considered of non-pharmaco included. Informatindicated the caustinterventions.	n-pharmacological sleep uation dated 4/15/2021, was stions that were left blank less that contribute to insomnia, the resident to fall asleep, "How esident wakes up at night" and ident complain about?" gical interventions or evaluation of effectiveness logical interventions was not ation included on assessment se of wakefulness during the		receiving scheduled sleep no insomnia have had a sleep notified of results. 4. How the corrective action monitored to ensure the practice recur: DON/Designee newly ordered medication 2 x week for one x wk for two months for app planning of non – pharmacor Results of finding will be revenentally and compliance value months. Corrective action complete.	nedication for log and MD on(s) will be ctice will not ed sleep e month then 1 ropriate care ological riewed in QAPI lidated after 3		
	PROVIDER OR SUPPLIE SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From p -Lorazepam (ben at bedtime for ins -Trazodone (antic for sleep (start da -Mirtazapine (anti for insomnia (star 4/19/2021) R13's care plan of 5/11/2021 indicate revised since 11/3 included; "The res medication Trazo (dated 9/13/2019) goal of the medic free from discomm to antidepressant date. The care pla improving sleep. Monitor/documen reactions to antid R13's care plan la individualized nor interventions. R13's Sleep Evaluation incomplete. Ques included; diagnos how long it takes many times the res "What did the res Non-pharmacolog utilized/attempted of non-pharmacolog utilized/attempted	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 -Lorazepam (benzodiazepine) 0.5 mg (milligrams) at bedtime for insomnia (start date 4/19/2021). -Trazodone (antidepressant) 100 mg at bedtime for sleep (start date 4/22/2020). -Mirtazapine (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) R13's care plan copied from R13's record on 5/11/2021 indicated the care plan had not been revised since 11/30/2020. The care plan included; "The resident uses antidepressant medication Trazodone r/t [related to insomnia" (dated 9/13/2019). 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Information included on assessment indicated the cause of wakefulness during the night was "unknown-denies pain, temperature,	PROVIDER OR SUPPLIER 10 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 11 COntinued From page 21 12 Lorazepam (benzodiazepine) 0.5 mg (milliligrams) at bedtime for insomnia (start date 4/19/2021). 13 -Trazodone (antidepressant) 100 mg at bedtime for sleep (start date 4/22/2020). 14 -Mirlazapine (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) 15 Trazodone (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) 16 Trazodone (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) 17 Trazodone (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) 18 Trazodone (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) 18 Trazodone (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) 19 Trazodone (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) 10 Trazodone (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) 11 Trazodone (antidepressant medication or revised since 11/30/2020. The care plan indicated the goal of the medication was "The resident was "The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. The care plan lacked a goal associated with improving sleep. Interventions included: 12 Trazodone (antidepressant) 15 mg at bedtime for insomnia (antidepressant) 16 mg at bedtime for insomnia (antidepressant) 16 mg at bedtime administration of individualized non-pharmacological interventions included: 18 Trazodone (brazodonia) 15 mg at bedtime for insomnia (antidepressant) 16 mg at bedtim	PROVIDER OR SUPPLIER 245499 245499 25TREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH OBECINENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 21 -Lorazepam (benzodiazepine) 0.5 mg (milligrams) at bedtime for insomnia (start date 4/19/2021)Trazodone (antidepressant) 10 mg at bedtime for sleep (start date 4/22/2020)Mirtazapine (antidepressant) 15 mg at bedtime for insomnia (start date 3/26/2021, stop date 4/19/2021) R13's care plan copied from R13's record on 5/11/2021 indicated the care plan had not been revised since 11/30/2020. 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R13's care plan lacked identification of individualized non-pharmacological interventions included: Monitor/document/report as needed adverse reactions to antidepressant therapy. R13's care plan lacked identification of individualized non-pharmacological interventions included: Monitor/document/report as needed adverse reactions to antidepressant therapy. R13's care plan lacked identification of individualized non-pharmacological interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245499	B. WING_			R-C / 13/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921	· · · · · · · · · · · · · · · · · · ·	110/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 758}	asleep and unable assessment concludifficulty falling and napping during the sleep since addition notified." R13's Point of Care record) documentate not available from a lacked an analysis sleep/wake pattern from the director of indicated she only days. R13's record lacke of non-pharmacolo or offered and lack effectiveness of an were used. R13's progress not "sleep assessment difficulty falling and napping during the sleep since addition." R13's progress not "Dr. [name of physics assessment with used to a provider in two weeks surveyor requested.	to stay asleep. The aded, "Resident complains of a staying asleep. Denies day. Denies improvement in n of Mirtazapine 3/26/20-MD e (POC-electronic health ation for sleep or awake was 3/26/21 to 4/15/21. The record of hours of sleep and s. In an Email communication for nursing dated 5/19/21, had access for the last 30 d evidence of documentation gical interventions attempted ed evidence of evaluation of y interventions if/when they de dated 4/15/2021, included at Resident complains of a staying asleep. Denies day. Denies improvement in a for mirtazapine 3/26-MD. de dated 4/19/2021 included, ician] review of sleep se of trazodone and dereceived to increase and at HS [bed time]. Update	{F 75	8}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	TE SURVEY MPLETED
		245499	B. WING			R-C / 13/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 425 NORTH BADGER STREET CALEDONIA, MN 55921		113/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
{F 758}	reviewed between sleep record lacked sleep/awake times analysis of sleep is continued to lack non-pharmacolog offered. R13's Sleep Evaluation completed with mevaluation when devaluation dated with a have difficulty falliwith the addition of the recorded on the formation of the recorded on the formation of the resident wake up recorded. The evanon-pharmacolog evaluation determisleeps throughout Resident states slimedication. States effective. States staying asleep." R13's record reviets 5/13/2021, continuon-pharmacolog offered. During an interviet director of nursing medication is addinon-pharmacolog and evaluated for	d and progress notes were 4/19/2021 and 5/7/2021, The ed documentation for s for all hours of the day, lacked nours/sleep patterns and	{F 75	8}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING			R-C / 13/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921		10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 758}	were not comprehe what R13's sleep processed factors, and if non-were attempted or is not an appropriational appropriational and the medication was needed. DON reverified the care planon-pharmacologics should have.	indicated the assessments ensive and lacked details of patterns, potential aggravating pharmacological interventions offered. DON stated insomnia ate diagnosis or indication for dicated the prescribing provided justification or ted she was not aware of why is scheduled nightly instead of eviewed R13's care plan and	{F 75	58}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEAL					CENTERS FOR ME	DICARE & MEL	DICAID SERVICES
					ND TRANSMITTAL		ID: TVJH
	PART 1 -	TO BE COMPI	LETED BY	THE STAT	E SURVEY AGENCY		Facility ID: 00073
1. MEDICARE/MEDICAID PROVII (L1) 245499	3. NAME AND ADDRESS OF FACILITY (L3) CALEDONIA REHABILITATION & I		RETIREMENT CENTER	4. TYPE OF AC			
2.STATE VENDOR OR MEDICAID	NO.	(L4) 425 NORTH	BADGER ST	FREET		1. Initial 3. Termination	2. Recertification 4. CHOW
(L2) 190176100		(L5) CALEDONI	A, MN		(L6) 55921	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF	FOWNERSHIP	7. PROVIDER/SU	PPLIER CATEO	GORY	<u>02</u> (L7)	7. On-Site Visit	
(L9) 07/01/2018		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey A	After Complaint
6. DATE OF SURVEY 02 /2	26/2021 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR EN	NDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	' IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers O	f The Following Requir	rements:
To (b):			equirements		2. Technical Personne	el _ 6. Scope o	of Services Limit
		,	e Based On:		3. 24 Hour RN	7. Medica	
12.Total Facility Beds	49 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural S	NF) _ 8. Patient I	Room Size
13.Total Certified Beds	49 (L17)	X B. Not in Con	npliance with Pro	gram	5. Life Safety Code	9. Beds/Ro	oom
			and/or Applied		* Code: B*	(L12)	
14. LTC CERTIFIED BED BREAKD	OOWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
49							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REI	MARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:
Lisa Krebs, HFE NE II		0	4/23/2021		Melissa Poepping, Enfo	rcement Specialist	04/27/2021
-		-		(L19)			(L2)
PA	ART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE	STATE AGENCY	7
19. DETERMINATION OF ELIGIB	ILITY		IPLIANCE WIT	H CIVIL	21. 1. Statement of Fin		
X 1. Facility is Eligible to	Participate	RIGI	HTS ACT:		 Ownership/Cont Both of the Abov 	rol Interest Disclosure S ve:	stmt (HCFA-1513)
2. Facility is not Eligib							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	V:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ATE .	VOLUNTARY 0	<u>INVO</u>	LUNTARY
10/01/1987					01-Merger, Closure	05-Fail	l to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur	rsement 06-Fail	l to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminat	ion OTHE	I.R
		n of Admissions:			04-Other Reason for Withdrawa		ovider Status Change
	•		(L44)			00-Act	tive
(L27)	B. Rescind St	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		

(L31)

(L33)

DETERMINATION APPROVAL

06201

04/27/2021

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



Electronically delivered March 19, 2021

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

RE: CCN: 245499

Cycle Start Date: February 26, 2021

Dear Administrator:

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

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 18, 2021.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

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

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

This Department is also recommending that CMS impose:

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

Caledonia Rehabilitation & Retirement Center March 19, 2021
Page 2
only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

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

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Caledonia Rehabilitation & Retirement Center March 19, 2021 Page 3

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

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

Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 26, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Caledonia Rehabilitation & Retirement Center March 19, 2021 Page 4

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

Caledonia Rehabilitation & Retirement Center March 19, 2021

Page 5

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

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

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145 Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245499	B. WING			C 02/26/2021		
NAME OF F	PROVIDER OR SUPPLIER	240400			REET ADDRESS, CITY, STATE, ZIP CODE	02/	26/2021	
CALEDO	NIA REHABILITATION	N & RETIREMENT CENTER			5 NORTH BADGER STREET ALEDONIA, MN 55921			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	000				
E 004 SS=C	Preparedness Req 2/25/2021 , during a facility is NOT in co Emergency Prepare	S Appendix Z Emergency uirements, was conducted on a recertification survey. The ampliance with the Appendix Z edness Requirements. Review and Update Annually	E 0	004			4/14/21	
	Federal, State and preparedness requidevelop establish a	irements. The [facility] must and maintain a comprehensive edness program that meets the						
		eparedness program must limited to, the following						
	and maintain an enthat must be [review	n. The [facility] must develop nergency preparedness plan wed], and updated at least plan must do all of the						
	§485.625(a):] Emer CAH] must comply State, and local em requirements. The develop and mainta emergency prepare	482.15 and CAHs at regency Plan. The [hospital or with all applicable Federal, lergency preparedness [hospital or CAH] must ain a comprehensive edness program that meets the s section, utilizing an ch.						
	Plan. The LTC facil	s at §483.73(a):] Emergency ity must develop and maintain						
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE	

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

(X6) DATE

Electronically Signed 03/27/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245499	B. WING			C 26/2021
	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	į UZII	20/2021
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E 004	an emergency prepreviewed and upda * [For ESRD Facilitic Plan. The ESRD facility f	aredness plan that must be ted at least annually. es at §494.62(a):] Emergency cility must develop and ency preparedness plan that I, and updated at least every 2 NT is not met as evidenced and document review, the ew the Emergency Operations y in accordance with the R 483.73. This had the II 34 residents currently ty. ge ii indicated, "This point Rehabilitation and gency Operations Plan (EOP) erstanding of how we manage is under emergency reviewed and updated if innual basis. This EOP has approved by our ership." The reviewed and	E 00	-The Facility's emergency prepare plan was reviewed and documente -Residents and staff have the abilit affected if the emergency prepared plan is not reviewed and document accordance to requirementsStaff educated on the importance reviewing and documenting the reviewing and documenting the reviewed are addit for 12 months on emergency preparedness plan will completed to ensure a documented review is presentAudit results will be reviewed at m QAPI to evaluate the effectiveness audit continuation -NHA/Designee is responsible -Corrective action completed by 4/	ed by to be diness ted in of view of the be d	
E 007 SS=C	EP Program Patien		E 00	7		4/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245499	B. WING			C 26/2021	
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	, , ,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
E 007	Continued From pa	ge 2	E 0	07			
	and maintain an em that must be review every 2 years. The (3) Address [patient but not limited to, poservices the [facility an emergency; and including delegation plans.** *[For LTC facilities as a series of the property	n. The [facility] must develop nergency preparedness plan yed, and updated at least plan must do the following:] t/client] population, including, ersons at-risk; the type of y has the ability to provide in continuity of operations, as of authority and succession at §483.73(a)(3):] Emergency					
	Plan. The LTC facilian emergency prepreviewed, and upda (3) Address resider not limited to, person the LTC facility has emergency; and co	ity must develop and maintain paredness plan that must be ated at least annually. In population, including, but ons at-risk; the type of services the ability to provide in an intinuity of operations, as of authority and succession					
	ASC, hospice, PAC RHC/FQHC, or ESI This REQUIREMEN by: Based on interview facility failed to add including the person preparedness plan. affect all 34 residen Findings include:	at risk" does not apply to: E, HHA, CORF, CMCH, RD facilities.] NT is not met as evidenced and document review, the ress their resident population as at risk in their emergency This had the potential to ats residing at the facility.		-The Facility's emergency prep plan addresses the resident pop served, including those at risk -Residents, including those at ri the ability to be affected if the el preparedness program does no the populationStaff educated on the importan addressing the resident populat	oulation sk, have mergency address ce of		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245499	B. WING				C 26/2021
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E 007		ge 3 ed the facility emergency plan population of persons served.	EC	007	the Facility's emergency preparedr plan -1x/quarter audit for 12 months on emergency preparedness plan will completed to ensure the resident population is addressed within the programAudit results will be reviewed at m QAPI to evaluate the effectiveness audit continuation -NHA/Designee is responsible -Corrective action completed by 4/	the be onthly of	
	Development of EP CFR(s): 483.73(b)	Policies and Procedures	ΕC	13	Gorrodavo dollori Gorripicioa By	,	4/14/21
	develop and implem policies and proced emergency plan se section, risk assess this section, and the paragraph (c) of this	t forth in paragraph (a) of this sment at paragraph (a)(1) of e communication plan at s section. The policies and e reviewed and updated at					
	procedures. The LT implement emerger procedures, based forth in paragraph (assessment at para and the communicathis section. The position of the procedures are the communication of the procedures are the procedures.	at §483.73(b):] Policies and C facility must develop and ncy preparedness policies and on the emergency plan set a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated at least annually.					
	procedures. The di	es at §494.62(b):] Policies and alysis facility must develop ergency preparedness policies					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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E 013	and procedures, baset forth in paragral assessment at paragraphic and up These emergencies to, fire, equipment of emergencies, water natural disasters like geographic area. This REQUIREMENT by: Based on interview facility failed to revisfor hazards deemed facility failed to revisfor hazards deemed facility's all hazards their emergency probasis in accordance CFR 483.73(a)(1)(2) could affect all 34 recould af	sed on the emergency plan oh (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated at least every 2 years include, but are not limited or power failures, care-related resupply interruption, and ely to occur in the facility's ely to occur in the facility and document review the ely policies and procedures designificant based on the risk assessment as part of ely ely the facility. 2/25/21, at 9:57 a.m. the ely the facility failed to review cies and procedure on an administrator verified the last	EO	-The Facility's EP Policies and Procedures for hazards deemed significant were reviewed -Residents have the ability to be if policies and procedures related hazards deemed significant are reviewed at least annually -Staff educated on the importance reviewing EP policies and procedures related to ensure the policies and procedures are reviewed at least annually -Staff educated on the importance reviewing EP policies and procedures and program will be completed to ensure policies and procedures are reviewed at QAPI to evaluate the effectiveness audit continuation -NHA/Designee is responsible -Corrective action completed by 4	to ot e of ures for mming n the EP ure wed and monthly s of	
E 015 SS=C		for Staff and Patients 1)	E 0		· · · · · ·	4/14/21
		ocedures. [Facilities] must nent emergency preparedness lures, based on the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ID PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245499	B. WING				C 26/2021
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E 015	emergency plan se section, risk assess this section, and the paragraph (c) of thi procedures must be 2 years (annually for policies and proced following: (1) The provision of and patients whether place, include, but a (i) Food, water, supplies (ii) Alternate so the following: (A) Temper health and safety a storage of provision (B) Emerger (C) Fire details alarm systems. (D) Sewager *[For Inpatient Host Policies and proced (6) The following arthospice-operated in The policies and profollowing: (iii) The provision of an arthospice employees evacuate or shelter limited to the follow (A) Food, we pharmaceutical supplies.	forth in paragraph (a) of this sment at paragraph (a)(1) of e communication plan at a section. The policies and e reviewed and updated everyor LTC). At a minimum, the lures must address the fures must address the fures must address the fures must address the fures of energy to maintain are not limited to the following: medical and pharmaceutical furces of energy to maintain furtures to protect patient and for the safe and sanitary instance in the safe and sanitary instance at \$418.113(b)(6)(iii):] dures for eadditional requirements for and waste disposal. The additional requirements for and patient care facilities only, occedures must address the confidence, include, but are not ing: water, medical, and oplies. It is sources of energy to	EC	15			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921	DDE	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
E 015	health and safety as storage of provision (2) Emo (3) Fire alarm systems. (C) Sewage This REQUIREMEN by: Based on interview facility failed to incluoperations plan (EC) pharmaceutical supsewage and waste emergency. This haresidents at the facility failed to obtain pharmaceuti would maintain sew during an emergency. During interview on administrator verifies	peratures to protect patient and for the safe and sanitary as. ergency lighting. detection, extinguishing, and and waste disposal. AT is not met as evidenced and document review, the ade in their emergency (P) how to obtain applies and how to maintain disposal during an ad the potential to affect 34 lity. BY'S EOP reviewed 7/26/19, address how they would cal supplies and how they wage and waste disposal cy. 2/25/21, at 10:00 a.m., the ad this information.	E 0	-The Facility's EP plan incluobtain pharmaceutical supp to maintain sewage and was during an emergencyResidents and staff have thaffected if needs of pharmaceutical sewage, and waste disposa addressed with in the EP Plestaff educated on the imporoactively planning for the needs for staff and residents the plans can be located with Plan1x/quarter audit for 12 monoprogram will be completed to subsistence needs for residing presentAudit results will be reviewed QAPI to evaluate the effection audit continuation -NHA/Designee is responsible-Corrective action completers.	lies and I ste dispo ne ability cy supplie I are not an rtance of subsister s and whe thin the E ths on th o ensure ents and ed at more veness of	to be es, f nce here EP e staff nthly of	4/14/21
SS=C	CFR(s): 483.73(b)(s) [(b) Policies and prodevelop and implementation policies and procedure)	ocedures. The [facilities] must nent emergency preparedness ures, based on the					
	emergency plan se	t forth in paragraph (a) of this					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED		
		245499	B. WING			C 26/2021		
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 425 NORTH BADGER STREET CALEDONIA, MN 55921				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
E 023	this section, and the paragraph (c) of this procedures must be least every 2 years minimum, the polician address the following [(5) or (3),(4),(6)] And documentation that protects confidentiates and maintan are secures and	sment at paragraph (a)(1) of e communication plan at s section. The policies and e reviewed and updated at (annually for LTC).] At a ies and procedures must ng:] system of medical preserves patient information, and ains availability of records. 403.748(b):] Policies and system of care documentation ving: ant information. entiality of patient information. entiality of patient information.	EO	-The Facility possesses a poprocedure addressing the premedical documentsResidents have the ability to if the facility does not have a of medical documents policy procedure within the EP prog-Staff educated on the import having a policy and procedure	be affected preservation and ram cance of			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET ALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 023	reviewed 7/26/19, v administrator. The fithat would preserve confidentiality of pa and maintain availa an emergency. During an interview administrator verific procedure to preser	vas reviewed with the facility had no system in place expatient information, protect tient information, and secure bility of records in the event of on 2/25/21, at 10:03 a.m. the ed there was not a policy or reve medical documents.	ΕO		the preservation of patient informate protect confidentiality of patient information, and secure and mainta availability of records in the event of emergency. -1x/quarter audit for 12 months on program will be completed to ensure Preservation of Medical Documents Policy and Procedure is within the Facility's EP Plan. -Audit results will be reviewed at m QAPI to evaluate the effectiveness audit continuation -NHA/Designee is responsible -Corrective action completed by 4/	ain If an the EP Te the S onthly of	
	CFR(s): 483.73(b)(a [(b) Policies and pro- develop and implent policies and proced emergency plan ser- section, risk assess this section, and the paragraph (c) of this procedures must be least every 2 years minimum, the policial address the following (8) [(6), (6)(C)(iv), (7) [facility] under a war Secretary, in accordant Act, in the provisional alternate care site in management official	pocedures. The [facilities] must ment emergency preparedness lures, based on the t forth in paragraph (a) of this ment at paragraph (a)(1) of ecommunication plan at section. The policies and ereviewed and updated at (annually for LTC).] At a es and procedures must ng:] 7), or (9)] The role of the iver declared by the dance with section 1135 of the n of care and treatment at an dentified by emergency	EO	26			4/14/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245499	B. WING _		02/3	26/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	1 02/2	20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 026	procedures. (8) The waiver declared by with section 1135 of at an alternative cale mergency manager. This REQUIREMED by: Based on document facility failed to devin its emergency plain providing care artistes under section potential to affect a residing in the facility. The facility emerged did not contain infoothe facility's role in at alternate care sittle During an interview administrator confir procedure, which services a sit of the facility's role in providing role in providing procedure, which services a sit of the facility's role in providing an interview administrator confir procedure, which services a sit of the facility's role in providing an interview administrator confir procedure, which services are sit of the facility's role in providing an interview administrator confir procedure, which services are sit of the facility's role in providing an interview administrator confir procedure, which services are sit of the facility's role in providing an interview administrator confir procedure, which services are sit of the facility's role in providing an interview administrator confir procedure, which services are sit of the facility's role in providing an interview administrator confir procedure, which services are sit of the facility is role in providing an interview and interview administrator confirmation and the facility is role in providing an interview and interview	e role of the RNHCI under a the Secretary, in accordance f Act, in the provision of care re site identified by ement officials. NT is not met as evidenced intreview and interview, the elop policies and procedures an describing the facility's role and treatment at alternate care 1135 act waiver. This had the li 34 residents currently	E 02	-The Facility possesses a policy a procedure addressing the Facility in providing care and treatment at alternative care sites under an 113 waiver. -Residents have the ability to be affirequired policies and procedures not included in the facility s EP platastaff educated on the importance comprehensive and compliant EP including the need for a policy and procedure regarding the facility s providing care and treatment at an alternative site under an 1135 waiventaxing the received at modern and the procedure is within the Facility s Plan. -Audit results will be reviewed at modern and the procedure is within the Facility s Plan. -Audit results will be reviewed at modern and the procedure is responsible to evaluate the effectiveness and the procedure is responsible and the procedur	ffected are an of a plan role in the EP and EP anonthly a of		
E 030 SS=C			E 03	·		4/14/21	
	emergency prepare that complies with I	st develop and maintain an edness communication plan Federal, State and local laws red and updated at least every					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	COMPLETED		
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER	•	4	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 030	2 years (annually for plan must include at (1) Names and confollowing: (i) Staff. (ii) Entities provarrangement. (iii) Patients' ph (iv) Other [facility) Other [facility) Volunteers. *[For Hospitals at § §485.625(c)] The conclude all of the fol (1) Names and confollowing: (i) Staff. (ii) Entities provarrangement. (iii) Patients' ph (iv) Other [hospitals at §4 communication plant following: (i) Volunteers. *[For RNHCIs at §4 communication plant following: (i) Staff. (ii) Entities provarrangement. (iii) Entities provarrangement. (iii) Next of kin, (iv) Other RNH (v) Volunteers.	or LTC).] The communication all of the following:] tact information for the viding services under sysicians ties]. 482.15(c) and CAHs at communication plan must lowing: tact information for the viding services under sysicians sitals and CAHs]. 603.748(c):] The must include all of the tact information for the viding services under sysicians sitals and CAHs].	EC	030			
	plan must include a	.45(c):] The communication Ill of the following: tact information for the					

	OF DEFICIENCIES OF CORRECTION	` IDENTIFICATION NI IMPED: ` ´		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245499	B. WING				C 26/2021	
	PROVIDER OR SUPPLIER	ON & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921	DE.	V		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE	
E 030	arrangement. (iii) Patients' p (iv) Volunteers *[For Hospices at communication plate following: (1) Names and confollowing: (i) Hospice en (ii) Entities produced arrangement. (iii) Patients' p (iv) Other hos *[For HHAs at §48 plan must include (1) Names and confollowing: (i) Staff. (ii) Entities produced arrangement. (iii) Patients' p (iv) Volunteers *[For OPOs at §48 plan must include (2) Names and confollowing: (i) Staff. (ii) Entities produced (2) Names and confollowing: (ii) Staff. (iii) Entities produced (2) Names and confollowing: (iii) Volunteers (iv) Other OPO	eviding services under shysicians. §418.113(c):] The an must include all of the intact information for the inployees. eviding services under shysicians. pices. 94.102(c):] The communication all of the following: intact information for the eviding services under shysicians. 96.360(c):] The communication all of the following: intact information for the eviding services under shysicians. 96.360(c):] The communication all of the following: intact information for the	EC					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245499	B. WING _		C 02/26/2021	
	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 030	OPO's Donation Set This REQUIREMEN by: Based on interview facility's communicate required information and contact number information for physical and set all 34 residual findings include: During interview on administrator acknowly sicians and their	ervice Area (DSA). NT is not met as evidenced and document review, the ation plan failed to include the including facility staff names are and names and contact sicians. This had the potential lents in the facility. 2/25/21, at 10:10 a.m. the owledged the was no list of a contact numbers or staff intact numbers information in	E 0	-The Facility's EP communication includes the required information including facility staff names and numbers, and contact information physiciansResidents have the ability to be if the EP communication plan does include staff and physician contain numbers and information -Staff educated on the importance having staff and physician contain numbers, and information within facility's EP plan -1x/quarter audit for 12 months of facility's EP communication plan completed to ensure the contact information is present and accurate Audit results will be reviewed at QAPI to evaluate the effectiveness audit continuation -NHA/Designee is responsible -Corrective action completed by a	contact in for affected es not ct e of ets, the in the will be list and ate. monthly as of	
	CFR(s): 483.73(c)(2 [(c) The [facility] mu emergency prepare that complies with F and must be review	ust develop and maintain an edness communication plan Federal, State and local laws red and updated at least every or LTC).] The communication	E 0	31		4/14/21
	(2) Contact informa	tion for the following: te, tribal, regional, and local				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C		
		245499	B. WING _			26/2021
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 031	*[For LTC Facilities information for the final state of the final stat	es of assistance. at §483.73(c):] (2) Contact following: te, tribal, regional, and local edness staff. censing and Certification of the State Long-Term Care tes of assistance. 83.475(c):] (2) Contact following: te, tribal, regional, and local edness staff. tes of assistance. Protection and Advocacy of and document review, the elop policy and procedure tact information for the had the potential to affect all currently resided in the facility. Ton 2/25/21, at 10:38 a.m. the properties of an edness communication plan, acumentation of contact	E 03	-The Facility's EP includes documentation of contact inform the Ombudsman -Residents have the ability to bif the Facility's EP plan does not documentation of contact inform the Resident's Ombudsman -Staff educated on the important comprehensive and compliant program including the contact if for the Ombudsman -1x/quarter audit for 12 months facility's EP plan will be compleensure the contact information Ombudsman is documented with	e affected of include mation for nce for a EP nformation on the efed to for the	

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET ALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 031	Continued From pa	ge 14	EC)31	accurateAudit results will be reviewed at m QAPI to evaluate the effectiveness audit continuation -NHA/Designee is responsible -Corrective action completed by 4/	of	
E 033 SS=C	Methods for Sharin CFR(s): 483.73(c)(•	ΕC)33	σ,		4/14/21
	emergency prepare that complies with I and must be review 2 years (annually fo plan must include a	ust develop and maintain an edness communication plan Federal, State and local laws wed and updated at least every or LTC).] The communication all of the following:					
	documentation for	patients under the [facility's], with other health providers to					
	release patient info CFR 164.510(b)(1)	event of an evacuation, to rmation as permitted under 45 (ii). [This provision is not under §484.102(c), CORFs					
	about the general of	ans of providing information ondition and location of facility's] care as permitted 510(b)(4).					
	sharing information patients under the I with care providers	03.748(c):] (4) A method for and care documentation for RNHCl's care, as necessary, to maintain the continuity of written election statement t or his or her legal					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
	245499	B. WING				2 6/2021
	& RETIREMENT CENTER		425	NORTH BADGER STREET		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG				(X5) COMPLETION DATE
representative. *[For RHCs/FQHCs of providing information and locatifacility's care as per 164.510(b)(4). This REQUIREMENT by: Based on interview facility failed to ens Operations Plan (E sharing information for patients under the necessary, with othe maintain the continupotential to affect at Findings include: The facility's EOP par policy and proceed facility would share resources during an interview administrator confirmed eveloped policies sharing information an emergency.	at §491.12(c):] (4) A means ation about the general on of patients under the rmitted under 45 CFR NT is not met as evidenced and document review, the ure their Emergency OP) included a method for and medical documentation he facility's care, as er health providers to uity of care. This had the li 34 residents at the facility. In a reviewed 7/26/19, lacked lure that addressed how the information with outside hemergency. In a 2/25/21, at 10:20 a.m. the med the facility had not and procedures related to with outside resources during			and procedure addressing how the Facility would share information with outside resources during an emerger. Residents have the ability to be affer if the facility does not have a method sharing information and medical documentation for patients under the facility's care, as necessary, with oth health providers to maintain the conficare. -Staff members educated on the importance of a comprehensive and complaint EP program including the for an information sharing to outside organizations during an emergency and procedure -1x/quarter audit for 12 months on the facility's EP plan will be completed to ensure the Policy and Procedure addressing information sharing with outside resources during an emergency present and accurate. -Audit results will be reviewed at mo QAPI to evaluate the effectiveness of audit continuation -NHA/Designee is responsible	n ency. ected d for e her tinuity I need e policy he o ency is onthly of	4/14/21
LIC and ICF/IID Sh	naring Plan with Patients	E 0	135			4/14/21
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From parepresentative. *[For RHCs/FQHCs of providing information and locatifacility's care as per 164.510(b)(4). This REQUIREMENT by: Based on interview facility failed to ens Operations Plan (E sharing information for patients under the necessary, with othe maintain the continue potential to affect at Findings include: The facility's EOP pare policy and proceed facility would share resources during at During an interview administrator confindeveloped policies sharing information an emergency.	PROVIDER OR SUPPLIER NIA REHABILITATION & RETIREMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Operations Plan (EOP) included a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care. This had the potential to affect all 34 residents at the facility. Findings include: The facility's EOP plan reviewed 7/26/19, lacked a policy and procedure that addressed how the facility would share information with outside resources during an emergency. During an interview on 2/25/21, at 10:20 a.m. the administrator confirmed the facility had not developed policies and procedures related to sharing information with outside resources during	ROVIDER OR SUPPLIER NIA REHABILITATION & RETIREMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Operations Plan (EOP) included a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care. 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ROVIDER OR SUPPLIER NA REHABILITATION & RETIREMENT CENTER SUMMARY STATEMENT OF DETICIENCIES (EACH DETICIENCY) SUMMARY STATEMENT OF DETICIENCIES (EACH DETICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 representative. "[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Operations Plan (EOP) included a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care. This had the potential to affect all 34 residents at the facility. Findings include: The facility's EOP plan reviewed 7/26/19, lacked a policy and procedure that addressed how the facility would share information with outside resources during an emergency. During an interview on 2/25/21, at 10:20 a.m. the administrator confirmed the facility had not developed policies and procedures related to sharing information with outside resources during an emergency and procedure that addressed how the facility would share information with outside resources during an emergency. PROVIDER TABORY THE ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDER ON THE ADDRESS, CITY, STATE, ZIP CODE (ALEOCOMICAL PROVIDED CALEDONIA, MN 55921 PROVIDER TABORY THE ADDRESS, CITY, STATE, ZIP CODE (ALEOCOMICAL PROVIDED CALEDONIA, MN 55921 PROVIDER TREET CALEDONIA, MS 5921 PROVIDER TREET CALEDONIA, MS 5921 PROVIDER TREE	ROVIDER OR SUPPLIER NA REHABILITATION & RETIREMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES: (EACH DEFICIENCY MUST BE PERCECTED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 representative. **[For RHCs/FQHCs at \$491,12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164,510(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility facility of care. This representative is represented to maintain the continuity of care. This had the potential to affect all 34 residents at the facility. The facility's Care, as necessary, with other health providers to maintain the continuity of care. This had the potential to affect all 34 residents at the facility. The facility score, as necessary with other health providers to maintain the continuity of care. The facility would share information with outside resources during an emergency. During an interview on 2/25/21, at 10:20 a.m. the administrator confirmed the facility had not developed policies and procedures related to sharing information with outside resources during an emergency policy and procedure addressing information sharing to outside organizations during an emergency policy and procedure addressing information in the continuity of care. -Staff members educated on the importance of a comprehensive and complaint EP program including the need for an information sharing to outside organizations during an emergency policy and procedure addressing information sharing with outside resources during an emergency policy and procedure addressing information sharing with outside resources during an emergency policy and procedure addressing information sharing with outside resources during an emergency policy and procedure addressing information sharing with outside resources during an emergency policy and procedure addressing information sharing with outside resources during an emergency poli

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C 26/2021
	PROVIDER OR SUPPLIE	ON & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921		20/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 035 SS=C	CFR(s): 483.73(c) *[For ICF/IIDs at § must develop and preparedness corwith Federal, Statreviewed and upon The communication following: *[For LTC Facilities facility must develop reparedness corwith Federal, Statreviewed and upon communication plant following: (8) A method for semergency plant, is appropriate, with families or repression appropriate, with fami	\$483.475(c):] [(c) The ICF/IID I maintain an emergency munication plan that complies to e and local laws and must be lated at least every 2 years.] on plan must include all of the local sat \$483.73(c):] [(c) The LTC lop and maintain an emergency munication plan that complies to e and local laws and must be lated at least annually.] The an must include all of the lated at least annually.] The an must include all of the late the facility has determined the residents [or clients] and their entatives. ENT is not met as evidenced lew and document review, the insure the Emergency EOP) was communicated to representatives. This had the all 34 residents who resided at least annually.] The late the facility is not met as evidenced lew and document review, the insure the Emergency EOP) was communicated to representatives. This had the all 34 residents who resided at least annually plan reviewed 7/26/19, lacked a method for sharing the emergency plan the facility propriate with residents and	EO	-Emergency Preparedness was shared with our existing and their families/representa Emergency Preparedness ir was made a part of new adn paperwork -Residents/their families/rep have the ability to be affecte information is not sharedStaff educated on importance expectation for EP information shared with residents/families representatives -2x/week audit for 1 month of	g residents atives. nformation nission resentatives d if EP ce and on to be	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMPLETED					
		245499	B. WING			C 02/26/2021	
	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 035	administrator confir developed a metho	ge 17 on 2/25/21, at 11:56 a.m. the med the facility had not d for sharing information from with residents and their	EC	035	admission paperwork will be complensure emergency preparedness information is shared with residents and/or their families or representati -Audit results will be reviewed at mQAPI to evaluate the effectiveness audit continuation -Admissions Coordinator/Designee responsible -Corrective action completed by 4/7	ves. onthly of	
	Hospitals at §482.1 HHAs at §484.102, §485.727, OPOs at §491.12:] (1) Train must do all of the fo (i) Initial training policies and proced staff, individuals pro arrangement, and we their expected roles (ii) Provide eme at least every 2 year (iii) Maintain do preparedness training (iv) Demonstrate emergency procedure (v) If the emergency procedures are [facility] must condu- policies and procedures at § hospice must do all	03.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, "Organizations" under §486.360, RHC/FQHCs at ing program. The [facility] ollowing: g in emergency preparedness ures to all new and existing oviding services under volunteers, consistent with sergency preparedness training ars. cumentation of all emergency ng. the staff knowledge of ares. ency preparedness policies e significantly updated, the act training on the updated ares.	E	037			4/14/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		245499	B. WING			C 02/26/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRES 425 NORTH BAIL CALEDONIA, I		, 02	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH (VIDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULE REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 037	policies and proced hospice employees services under arra expected roles. (ii) Demonstrate emergency procedure (iii) Provide em training at least ever (iv) Periodically emergency prepare employees (including special emphasis procedures necess others. (v) Maintain do preparedness training (vi) If the emergency procedures and procedures are (ii) After initial training policies and procedures are (iii) Demonstrate emergency procedures are emergency procedures are gand procedures are	lures to all new and existing , and individuals providing ngement, consistent with their estaff knowledge of cres. ergency preparedness ery 2 years. ereview and rehearse its edness plan with hospice and nonemployee staff), with laced on carrying out the ary to protect patients and cumentation of all emergency ing. gency preparedness policies estignificantly updated, the act training on the updated dures. 1.184(d):] (1) Training must do all of the following: gin emergency preparedness lures to all new and existing eviding services under volunteers, consistent with seraining, provide emergency ing every 2 years. The staff knowledge of cures. The cumentation of all emergency ing every 2 years. The staff knowledge of cures is estaff knowledge of cures. The cumentation of all emergency ing. The cumentation of all emergency ing.	EC	37			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	COMPLETED	
		245499	B. WING			C / 26/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
E 037	Program. The LTC following: (i) Initial training policies and proced staff, individuals programment, and witheir expected role. (ii) Provide emergency at least annually. (iii) Maintain do preparedness training (iv) Demonstrate emergency proced to the control of the control	at §483.73(d):] (1) Training facility must do all of the g in emergency preparedness dures to all new and existing oviding services under volunteers, consistent with ergency preparedness training ocumentation of all emergency ing. It estaff knowledge of ures. 85.68(d):](1) Training. The of the following: all training in emergency ies and procedures to all new individuals providing ingement, and volunteers, in expected roles. It estaff knowledge of ures. It estaff knowledge of ures. All new personnel must be signed specific in regarding the CORF's thin 2 weeks of their first ing program must include cation and use of alarm is and firefighting equipment. In regency preparedness policies is significantly updated, the cet training on the updated	E O	37			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C / 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 037	program. The CAH (i) Initial trainin policies and proced reporting and extin and where necessa personnel, and gue cooperation with authorities, to all ne individuals providin arrangement, and their expected role (ii) Provide em at least every 2 yea (iii) Maintain do (iv) Demonstra emergency proced (v) If the eme and procedures are CAH must conduct policies and proced *[For CMHCs at §4 CMHC must provid preparedness polic and existing staff, i under arrangemen with their expected documentation of t demonstrate staff k procedures. There emergency prepare years. This REQUIREME by: Based on interview	5.625(d):] (1) Training I must do all of the following: g in emergency preparedness dures, including prompt guishing of fires, protection, ary, evacuation of patients, ests, fire prevention, and firefighting and disaster ew and existing staff, ag services under volunteers, consistent with s. ergency preparedness training ars. becumentation of the training. te staff knowledge of ures. rgency preparedness policies e significantly updated, the training on the updated	EO	-EP Training and Risk Asserpart of general new hire orie		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245499	B. WING				26/ 2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET CALEDONIA, MN 55921	OZ.	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	This had the poten and staff. Findings include: During an interview human resources of completed on an addocumentation to it.	ons plan (EOP) plan with staff. tial to affect all 34 residents on 2/25/21, at 10:31 a.m. confirmed EOP training was annual basis however, lacked adicate the facility had training a the emergency plan and risk eted by the facility.	E (-Staff and residents have the ability affected if EP training does not occupon hire -Staff educated on the key element policies/procedures, of the Facility's program. New Hire Orientation incl EP training and Risk Assessment2x/week audit for 1 month on new orientation will be completed to ensemergency plan and risk assessment training is presentAudit results will be reviewed at m QAPI to evaluate the effectiveness audit continuation -HR/Designee is responsible -Corrective action completed by 4/2	s and s EP udes hire sure ent onthly of	
	On 2/22/21, through recertification survey facility. A complaint conducted. Your facompliance with the 483, Subpart B, Recare Facilities. The following compunsubstantiated H5499044C (MN63) The following compsubstantiated H5499042C (MN63) The following compsubstantiated H5499043C (MN63) The following compsubstantiated H5499043C (MN63)	gh 2/26/21, a standard ey was conducted at your t investigation was also cility was found not in e requirements of 42 CFR equirements for Long Term plaints were found to be ED: 8661) plaints were found to be with no deficiency: 2507) 9239) plaints were found to be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245499	B. WING _		C 02/26/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	, 02	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 567 SS=E	F623, F625, and F The facility's plan of as your allegation Department's acceenrolled in ePOC, at the bottom of the form. Your electron be used as verificated Upon receipt of an an on-site revisit of conducted to valid with the regulation accordance with your electron/Manage CFR(s): 483.10(f)(10) The manage his or her the right to know, if acility may impose funds. (i) The facility must deposit their person resident chooses to the facility, upon working the facility is section. (ii) Deposit of Fund (A) In general: Excellity (B) of this section. (iii) Deposit of Fund (A) In general: Excellity (B) of this section.	2263), citations issued at 880 of correction (POC) will serve of compliance upon the eptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will ation of compliance. acceptable electronic POC, f your facility may be ate that substantial compliance is has been attained in our verification. The ement of Personal Funds 10(i)(ii) The resident has a right to financial affairs. This includes in advance, what charges are against a resident's personal it not require residents to anal funds with the facility. If a condeposit personal funds with rritten authorization of any must act as a fiduciary of the individual funds of the with the facility, as specified in	F 00			4/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245499	B. WING		C 02/26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 567	accounts, and that resident's funds to accounts, there must for each resident's maintain a resident exceed \$100 in a ninterest-bearing ac (B) Residents whose The facility must defunds in excess of account (or account of the facility's oper credits all interest exthat account. (In positive a separate account The facility must most exceed \$50 in a interest-bearing act This REQUIREMED by: Based on interview facility failed to kee the resident funds any resident funds any resident funds account. This had the residents that had account with the faction of the facility failed to kee the residents that had account with the faction of	redits all interest earned on that account. (In pooled state a separate accounting share.) The facility must 's personal funds that do not on-interest bearing account, count, or petty cash fund. See care is funded by Medicaid: eposit the residents' personal \$50 in an interest bearing accounts; that is separate from any rating accounts, and that earned on resident's funds to coled accounts, there must be ting for each resident's share.) aintain personal funds that do a noninterest bearing account, count, or petty cash fund. NT is not met as evidenced or and record review, the p an accounting of money in accounts and failed to keep money in an interest-bearing he potential to affect all 12 money in a personal fund	F 567	-Resident funds and records are up-to-date and accurate. Resident are in an interest-bearing accountResidents with personal trust fund the ability to be affected if accounti records are not current and accura within an interest-bearing accountBOM Staff Member educated on importance of current and accurate resident personal funds and need finterest-bearing account. A new ba account that is an interest-bearing account was established and Reside Funds are appropriately within. The facility created a spreadsheet of Reaccounts that is currently being maintained. The facility utilizes Points.	s have ng and te or for an nk dent e esident

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245499	B. WING			C 26/2021
	NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
to accord to acc	count from the baceposits. The BOM ere kept in a chect aving account. The bing to work with he to an interest-bear liked to the bank a policy on personal quested and not preview of the facility as a policy on personal quested and not preview of the facility as a policy on personal quested and not preview of the facility as a policy on personal account (or account and account (or account and account (or account and account (In poseparate account and accounts). Residents who experience the personal funds in exterest-bearing accounts, and that accounts, and that accounts, there must be accounts, there must be accounts, there must be accounts and the accounts accounts and the accounts accounts accounts and the accounts accounts accounts and the accounts a	ank documentation of stated the resident funds king account rather than a e BOM stated the bank was per to get money transferred ring account and stated she bout that this afternoon. If funds accounts was provided. If sy's "Combined Federal and given to the residents and tives during admission]" with 11/28/16 revealed under " "Deposit of fundsa. The sany residents' personal stolents and that is separate from any pating accounts, and that arned on resident's funds to oled accounts, there must be sing for each resident's share.) are care is funded by the must deposit the residents' access of \$50. In an account (or accounts) that is soft the facility's operating credits all interest earned on that account. (In pooled st be a separate accounting share.)."	F 5	Care and will be utilizing the 'A for Trust Accounts once the PC Tab goes live. BOM was educa policy and expectation of Resid Accounting and Records to mit citation. -1x/week audit for 2 months or funds will be completed to ensuccounting and records are cu accurate -Audit results will be reviewed QAPI to evaluate the effectiver audit continuation -BOM/Designee is responsible -Corrective action completed by	C Admin ted on the lent igate future personal ure rent and at monthly ess of	4/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499 B. WING		C 02/26/2021			
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER				42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET ALEDONIA, MN 55921		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 568	system that assures separate accounting accepted accounting resident's personal on the resident funds with funds of any person (C) The individual find available to the resistatements and upon This REQUIREMENT by: Based on interview facility failed to province in the province accounting principle affected all 12 residuance accounts overseen. Findings include: During an interview stated they had not statement from the puring an interview the business office had a personal trustindicated R10 was stated the previous was the 1/16/21 and stated the previous was t	is a full and complete and g, according to generally g principles, of each funds entrusted to the facility shalf. Is the preclude any commingling the facility funds or with the nother than another resident. In ancial record must be dent through quarterly on request. In and document review, the vide quarterly statements for and document review, the vide quarterly statements for unts for 4 of 4 residents (R10, eviewed. In addition, the nation a separate accounting of ds and failed to follow the ses for the accounts. This lents who had resident fund by the facility. On 2/22/21, at 6:51 p.m. R10 received a quarterly	F 5	68	-Quarterly Trust Statements were to Residents/Responsible Parties versident accounts overseen by the facilityResidents with fund account overseen by the facilityResidents with trust accounts have potential to be affected if quarterly statements are not issued or if residence accounting records are not separated. BOM Staff Member educated on the need for quarterly trust statements issued and the expectation that Refund accounts are separate and maintained. The facility created a spreadsheet of Resident Accounts individual currently being maintained facility utilizes Point Click Care and utilizing the 'Admin' Tab for Trust Accounts once the PCC Admin Tablive. BOM was educated on the pole expectation of Resident Accounting Records/Quarterly Statements to refuture citation1x/month audit for 12 months on refutive statements on refutive statements.	vith ility. resent nts e the dent's te. the to be sident that is ed. The I will be o goes licy and g and nitigate	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245499	B. WING _			C / 26/2021
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 568	During an interview the administrator are last week quarterly sent to residents. To stated the previous were behind on ser and stated they had records of when last sent out to resident resident had trust at unable to determine money was in each stated she was plant the deposit slips to was in each accound documentation of different than a saving the bank was going money transferred account and stated that this afternoon. A policy on personal requested and not provided the position of the policy of Changes (CFR(s): 483.10(g)(14) Not (i) A facility must improve consistent with his representative(s) with accident inverse.	quarterly statements. on 02/25/21, at 12:25 p.m. and BOM stated they identified statements were not being he administrator and BOM person had indicated they ading out quarterly statements to been unable to find any statements were so the BOM stated 12 current and the facility was eat this time how much resident account. The BOM aning to go to the bank to get figure out how much money at from the bank eposits. The BOM stated the except in a checking account graceount. The BOM stated to work with her to get into an interest- bearing she talked to the bank about all funds accounts was provided. Injury/Decline/Room, etc.) 14)(i)-(iv)(15) iffication of Changes. Indent's physician; and notify, or her authority, the resident	F 56	trust statements and Resident will be completed to ensure state are being issued at least quarter accounts are separate and marked and the entry of	atements erly and intained. t monthly ness of	4/14/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C / 26/2021
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 425 NORTH BADGER STREET CALEDONIA, MN 55921	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 580	mental, or psychos deterioration in hea status in either lifeclinical complication (C) A need to alter a need to discontin treatment due to accommence a new f (D) A decision to traresident from the fa §483.15(c)(1)(ii). (ii) When making notice (14)(i) of this section all pertinent informatical per	ange in the resident's physical, ocial status (that is, a alth, mental, or psychosocial threatening conditions or ns); treatment significantly (that is, ue an existing form of diverse consequences, or to form of treatment); or ansfer or discharge the acility as specified in cotification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the stalso promptly notify the sident representative, if any, or or roommate assignment 3.10(e)(6); or sident rights under Federal or tions as specified in paragraph on. St record and periodically is (mailing and email) and	F 5	80		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245499		B. WING		02/26/2021			
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 580	under §483.15(c)(9) This REQUIREMENT by: Based on interview facility failed to notion injury following a nelift for 1 of 3 resider accidents. Findings include: R23's quarterly Minassessment, dated had moderately impextensive assistant toilet use, personal locomotion on the unidentified a diagnost (ESRD), and receive R23's care plan, indextensive assistant stand (mechanical R23's current physitablet (a narcotic modiligrams) give or hours as needed for R23's nursing progression indicated resident pulled her nursing assistant) wasked to use the easy stand while getting her of slide out because the second interview of the second while getting her of slide out because the second interview of the s). NT is not met as evidenced y and document review the fy the physician of a shoulder ear miss fall from the standing nts (R23) reviewed for imum Data Set (MDS) 1/5/21, indicated the resident paired cognition and required the with bed mobility, transfers, hygiene, dressing, and unit. The MDS further his of end stage renal disease hed dialysis services. dicated the resident required the from one staff with the EZ machine). cian orders included: Lortab medication) 5-325 mg me tablet by mouth every 8	F 580	 Immediate action(s) taken for resident(s) found to have been affer include: R23 Physician Notified 3/2/21. No in order by the physician. Identification of other residents the potential to be affected was accomplished by: Residents records audit for the part days. 6 residents had falls and pot to be affected physician was notific physician orders followed as indicated: Actions taken/systems put into to reduce the risk of future occurred include:	change s having st 30 cential ed and ated. o place ence rviced elated or near the MD e April		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245499	B. WING				26/ 2021
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	floor and called for the floor into there in the floor into the floor transfer after her disched passed out, is in the floor in the floor in the floor. Turther review of R include evidence the resident's complain the incident on 1/30 to the floor. When interviewed of the floor into the floor.	help. She was assisted off bed. Denied injury. ress note dated 1/30/21 at : Resident requested pain tablet 10-325 mg oulder pain 6/10 (rated 6 out I Therapy Treatment ted 2/1/21 included: s fall over the weekend - was from the EZ stand during a alysis, reports was dizzy, feels now having left shoulder and est but 4/10 with any AROM tion) and resistive use;	F 5	80	monitored to ensure the practice werecur: DON or designee will audit for MD change of condition r/t falls or near falls documented notification 2x/we one month then 1 x wk for two mor Results of finding will be reviewed QAPI monthly to validate complian 3 months. Corrective action completion da04/14/2021	miss eek for nths. in ce after	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, C 425 NORTH BADGE CALEDONIA, MN		1 OZI	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTIO RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	returned from dialys commode while bei light-headed and m when this happene her shoulders caus confirmed her shoulders caus confirmed her shoulders caus confirmed her shoulders caus confirmed her should the next morning at afterwards. R23 st therapy because he muscles were so so move my arms". Roccupational therapon her neck; it was the pain continued yawning her neck in surprised they didn R23 confirmed she know about the should feel a little so to be to baseline. When interviewed or registered nurse (Roccurred and verified was prior to R23's i confirmed she had related to R23's c/or	sis and after using the ing transferred to bed, felt ust have fainted. R23 stated d the sling pulled up around ing her arms to go up. R23 lders didn't hurt at first but did	F 5	80			
	A policy on notificat requested but not re	ion to physician was eceived.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	CON	TE SURVEY MPLETED
		245499	B. WING _			C / 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 584 SS=D	CFR(s): 483.10(i)(1) §483.10(i) Safe Entitle The resident has a comfortable and he but not limited to resupports for daily limited to resuppossible. (i) This includes entreceive care and sephysical layout of the independence and (ii) The facility shall the protection of the or theft. §483.10(i)(2) House services necessary orderly, and comfort §483.10(i)(3) Clear in good condition; §483.10(i)(4) Private resident room, as sephysical lareas; §483.10(i)(5) Adequates in all areas;	vironment. right to a safe, clean, melike environment, including receiving treatment and ving safely. ovide- e, clean, comfortable, and ent, allowing the resident to onal belongings to the extent suring that the resident can ervices safely and that the ne facility maximizes resident does not pose a safety risk. I exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary,	F 58	34		4/14/21

NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES DESCRIPTION OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDER'S PLAN OF CORRECTION	AND PLAN OF CORRI	EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921 ID PROVIDER'S PLAN OF CORRECTION			245499	B. WING _				
					425 NORTH BADGER STREET			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX (E	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETION DATE	
§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide a homelike environment during dining to 1 of 1 of residents (R13) who was observed eating from breakfast from a Styrofoam container. Findings include During an observation and interview on 2/23/2021, at 11:35 a.m. R13 sat in his wheelchair in his room, the right side of his wheel chair had an attached arm rest with a divided Styrofoam container containing sausage links. An unidentified dietary aide (DA) was in R13's room inquiring what he would like for lunch. DA stated residents were served breakfast in the Styrofoam but did not know why. R13's nutritional care plan dated 12/1/2020, included honor resident food preferences, provide adaptive equipment as needed: large handled silverware. R13's activities of daily living care plan dated 9/6/2019, for eating included provide finger food when the resident has difficulty using utensils. During an interview on 2/23/2021, at 4:36 p.m. R13 was sitting up in his wheelchair in his room. R13 stated he did not like eating out of the Styrofoam containers and would prefer not to. R13 stated sometimes it was difficult to eat from them.	§483. sound This F by: Base review environ (R13) from a Findin During 2/23/2 wheel chair I Styrof unider inquiri reside but did R13's includ provided handle care perovided difficured During R13 were R13 se Styrof	3.10(i)(7) For the devels. REQUIREME sed on observations who was obtained an attack of the contained and attack of the contained and the c	tion, interview, and document ailed to provide a homelike g dining to 1 of 1 of residents served eating from breakfast container. Ition and interview on 5 a.m. R13 sat in his bom, the right side of his wheel hed arm rest with a divided er containing sausage links. An aide (DA) was in R13's room would like for lunch. DA stated wed breakfast in the Styrofoam why. In are plan dated 12/1/2020, ident food preferences, quipment as needed: large at R13's activities of daily living 6/2019, for eating included when the resident has nesils. In on 2/23/2021, at 4:36 p.m. in his wheelchair in his room. not like eating out of the ers and would prefer not to.	F 5	-R13 was interviewed regarding ware preference and his prefere being honoredResidents have the ability to be if their plate wear preferences a supported -Multidisciplinary Staff educated importance of asking and uphol resident preferences in line with person-centered care. In house Residents were offered to fill ou Resident Preferences sheet for records. The Resident Preferen document is to be incorporated care conferences to capture Re Centered Care preferences2x/week audits for 2 months or preferences will be completed to resident centered care that emp comfort, independence, personand preferences is honored -Audit results to be reviewed at QAPI to evaluate the effectivent audit continuation -Social Services/Designee is resident preferences.	affected re not on the ding a their ces nto initial sident Resident Resident Resident a ensure hasizes all needs, monthly ess of sponsible		

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL A. BUILDING (X3) DATE S		E SURVEY IPLETED			
		245499	B. WING			C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	•	
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F 623 SS=D	2/24/2021, at 7:12 his room, certified delivered R13's brocontainer. CDM stamanager had start because of COVID between breakfast dinnerware. Facility policy Quaenvironment dated 1) Staff shall provide emphasizes the reindependence, and preferences. 3) The facility staff minimize, to the excharacteristics of the depersonalized, in Notice Requirement CFR(s): 483.15(c)(s) White Resident, the facility (i) Notify the resident, the facility (ii) Notify the resident representative (s) of the reasons for the language and man facility must send a representative of the Long-Term Care C (iii) Record the reasons discharge in the reaccordance with pand	tion and interview on a.m. R13 sat up in his chair in dietary manager (CDM) eakfast to him in a Styrofoam ated that the previous dietary ed using Styrofoam containers 0-19; there wasn't a lot of time and lunch to clean the lity of Life-Homelike 12/2014, included: de person-centered care that sidents' comfort, dipersonal needs and and management shall atent possible, the he facility that reflect a stitutional setting. Into Before Transfer/Discharge (3)-(6)(8) The before transfer and the resident's of the transfer or discharge and a move in writing and in a mer they understand. The acopy of the notice to a he Office of the State	F 5			4/14/21

	OF DEFICIENCIES OF CORRECTION			(>	(3) DATE SURVEY COMPLETED	
		245499	B. WING		_	C 02/26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STAT 425 NORTH BADGER STREI CALEDONIA, MN 55921		V2 :20:202
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F 623	paragraph (c)(5) of §483.15(c)(4) Timin (i) Except as specific (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be resident is transferr (iii) Notice must be resident is transferr or d (A) The safety of into be endangered und this section; (B) The health of into be endangered, und this section; (C) The resident's hallow a more immedunder paragraph (c) (D) An immediate the required by the resident paragraph (c) (E) A resident has redays. §483.15(c)(5) Contonotice specified in pmust include the fol (i) The reason for to (ii) The effective dar (iii) The location to transferred or disch (iv) A statement of the including the name, and telephone num receives such required to obtain an appeal	this section. In g of the notice. In g of the notice of transfer or In g of the notice. In g of the notice of transfer or discharge, In g of the notice. In g of the notice of transfer or discharge, In g of the notice of the written of the notice. In g of the notice of the written of the notice of the notice of the notice of the section of the notice of the notice of the notice of the section of the notice of the notic	F 6	523		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245499	B. WING				26/2021
	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		425	EET ADDRESS, CITY, STATE, ZIP CODE NORTH BADGER STREET LEDONIA, MN 55921	<u> VZII</u>	20/2021
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F 623	hearing request; (v) The name, addrtelephone number of Long-Term Care Or (vi) For nursing faciand developmental disabilities, the mai telephone number of the protection and adevelopmental disabilities, the mai telephone number of the protection and adevelopmental disabilities, the mai telephone number of the protection and adevelopmental disabilities. C of the Developmental disabilities of the Individual	ess (mailing and email) and of the Office of the State inbudsman; lity residents with intellectual disabilities or related ling and email address and of the agency responsible for advocacy of individuals with ibilities established under Part ental Disabilities Assistance of 2000 (Pub. L. 106-402, C. 15001 et seq.); and ility residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder the Protection and Advocacy iduals Act. Inges to the notice. The notice changes prior to be or or discharge, the facility cipients of the notice as soon the updated information	F6	23			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (A. BUILDING		E SURVEY PLETED			
		245499	B. WING			C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP C 425 NORTH BADGER STREET CALEDONIA, MN 55921	•	
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F 623	This REQUIREMEI by: Based on interview facility failed to promotices to the residing representative who and failed to accura State Long-Term Chospital transfers for reviewed for hospital transfers for hospital transfers for reviewed for hospital transfers for hospital transf	NT is not met as evidenced v and document review, the vide written hospital transfer ent(s) and/or resident's had a facility-initiated transfer ately notify the Office of the are Ombudsman (OMB) of or 2 of 2 resident (R136, R2) alizations. Ottes dated 5/19/2020, at 9:47 sident hollering out from her nin easy reach. Resident teary rts not being able to walk by assistance of 2 staff to transfer wheelchair and from chair belt. Temp [Temperature] espirations] 16, [blood ungs clear, offers no Color pink, oxygen 1L [liter] ons] via nasal cannula. e would like to be seen in ED ment]. Call out to [certified]	F 6	1. Immediate action(s) tal resident(s) found to have be include: R136 has since discharged facility on 5/19/20. R2 was transferred from M hospital on 3/8/21. Resider facility on 3/15/21. Ombuds via email on 3/24/21. 2. Identification of other rethe potential to be affected accomplished by: Audit completed of current past 30 days for validation hospital/discharge for ombinotification. One other residuate the risk of future include: DON in service on 3/24/21 clinical consultant on ombudischarge/transfer notification. One other residuce the risk of future include: DON in service on 3/24/21 clinical consultant on ombudischarge/transfer notification. One other residuce the risk of future include: DON contact Ombudsman his preferred method of confrequency. New Social worker will be induring orientation. 4. How the corrective actimonitored to ensure the prarecur: DON or designee will audit Ombudsman notification of discharges for 2/week for or designee for 2/week for or designee will audit of the prarecur.	d from the D appt to nt returned to sman notified esidents having was residents for of transfer of udsman dent had put into place occurrence via zoom with udsman ion. on 3/11/21 for ntact and in serviced ion(s) will be actice will not of transfers or	

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F 623	number a business going to try calling Ambulance took redepartment]." R136's medical reconotification and/or restatement of the reinformation on how and it lacked the coof the States Long-During an interview director of nursing documentation of resident/resident rethe ombudsman of medical record. The aware the ombudshospitalization need During an interview registered nurse (Raware the ombudshospitalization need p.m. included, "recorresident is to be se [emergency depart NP updated." R2's medical record the State's Long-Tenotified of the transent R2's progress note a.m. included, "Resent R2's progress note a.m. included, "R2's pro	Imedical doctor MD-A] is family change of condition. Sident to ED [emergency] ord lacked evidence of reason regarding transfer, the sidents' appeal rights or an appeal form was obtained, ontact information of the Office Term Care Ombudsman. on 2/24/21, at 8:10 a.m. the (DON) stated she did not see reason for transfer to the representative or notification of R136's hospitalization in her a DON stated she was not man notification of a resident's ded to be done. on 2/26/21, at 9:26 a.m. and the resident of the resident o	F6	1 x wk for two months. Res will be reviewed in QAPI m validate compliance after 3	onthly to	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION DING	(X3)) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 425 NORTH BADGER STREET CALEDONIA, MN 55921	DE	OE/EO/EOE 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	note indicated the process medical record notification and/or restatement of the resinformation on how and it lacked notific Care Ombudsman. During an interview director of nursing (documentation of the appeal right or inforwas obtained, and information of the Care Ombudsman. The Transfer and D [against medical adincluded, "Provide a practicable to reside Services Director, onotice of transfer to Long-Term Care Or Notice of Bed Hold CFR(s): 483.15(d) (1) S483.15(d) (1) Notice of the resident goes nursing facility must the resident or residence (i) The duration of the continuous of the second continuous of the resident or residence (ii) The duration of the continuous of the second continuous of the resident or residence (ii) The duration of the continuous o	chysician was updated. Id lacked evidence of leason regarding transfer, the sidents' appeal rights or an appeal form was obtained, ation to the State's Long Term If on 2/26/2021, at 2:00 p.m. If (DON) stated she did not see the statement of resident's mation on how to appeal form it lacked the contact office of the States Long-Term In the states of the States Long-Term It is charge (including AMA livice) policy dated 2020 a transfer notice as soon as ent and representative. Social or designee, shall provide a representative of the State mbudsman via monthly list." Policy Before/Upon Trnsfr		325		4/14/21
		residence in the nursing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 625	plan, under § 447.4 (iii) The nursing fact bed-hold periods, we paragraph (e)(1) of resident to return; a (iv) The information of this section. §483.15(d)(2) Bed-the time of transfer hospitalization or the facility must provide resident represents specifies the duratic described in paragraments and the potential to prove residents or resident facility failed to prove resident failed fa	d payment policy in the state to of this chapter, if any; sility's policies regarding which must be consistent with this section, permitting a and a specified in paragraph (e)(1) whold notice upon transfer. At of a resident for herapeutic leave, a nursing to the resident and the ative written notice which on of the bed-hold policy raph (d)(1) of this section. NT is not met as evidenced and review and interview, the wide written bed hold notice to the representatives at the time sees of emergency transfer, at specified policies regarding eserve bed payment. This had not 2 of 2 residents (R136, R2)	F 625	1. Immediate action(s) taken for tresident(s) found to have been affer include: R139 care plan was updated 2/26/at risk for abnormal bleeding, spontaneous bleeding, potential hemorrhage and/or increased/easy bruising r/t taking anticoagulant. 2. Identification of other residents the potential to be affected was accomplished by: Current resident records audit for the 30 days to ensure that a comprehencare plan was implemented with all required elements of the individual resident needs. 3. Actions taken/systems put into to reduce the risk of future occurre include:	ected 21 for y s having the past ensive

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP		E SURVEY PLETED				
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 625	complaints of pain. 85% sats [saturation Resident states she [emergency depart nurse practitioner of R136's progress not a.m. included, "[CNED [emergency de [due to] change of resident to ED [emergency depart family, did not leave number a business going to try calling Ambulance took redepartment]." R136's medical record failed written bed hold notice for requested, but not During an interview director of nursing documentation of a record. At, 8:31 a.m.	ungs clear, offers no Color pink, oxygen 1L [liter] ons] via nasal cannula. e would like to be seen in ED ment]. Call out to [certified CNP-A]. ote dated 5/19/2020, at 10:21 IP-A] returned call; to send to partment] via ambulance d/t condition. Ambulance took ergency department]." ote dated 5/19/2020, at 4:42 er resident sent to ED ment], this nurse tried calling e a message due to phone e. [medical doctor MD-A] is family change of condition. sident to ED [emergency cord lacked evidence that staff ed hold notice to the resident or ative at the time of transfer to onin 24 hours of emergent view of R136's paper chart, anned into the electronic ed to provide evidence that a office was provided. A copy of a the hospitalization was	F 628	Licensed nursing staff will be in on the Baseline care plan proce requirements by April 14, 2021. nurses starting after April 14, 20 in serviced during orientation or process. DON/designee will validate in fi hours, baseline care plan meeti scheduled. DON/designee will validate 48 h baseline care plan complete will diagnosis related interventions. 4. How the corrective action(s monitored to ensure the practic recur: DON or designee will audit care 2x/week for one month then 1 x two months. Results of finding veriewed in QAPI monthly to vacompliance after 3 months.	ess and Licensed 021 will be in this rst 24 ing nour ih) will be e will not e plans wk for will be	

AND DUAN OF CORRECTION TO THE PROPERTY OF THE		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		245499	B. WING			C / 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 625	done a bed hold in worked there and s would only do a bed. The DON stated he resident goes to hot to the resident sign the bed DON stated the state they had a packet to DON stated a copy given to the resider copy would be kept During an interview registered nurse (R was above a certain needed, but if cens do not require a be unaware of the perstated she has nev. During an interview family member (FM hospitalized the fact would always would Resident #2 R2's progress note p.m. included "Resiname of hospital] fis currently on a besident is to be severe in the power of the perstand the p.m. included, "recoveresident is to be severesident is to be severed."	all the years RN-A had tated RN-A had told her they d hold if the facility was full. For expectation was when a spital, staff inform family, talk are they leave and have the ed hold form in possible. The ff should inform the family o sign for the bed hold. The of the bed hold would be not or representative and a strong for the facility. For on 2/26/21, at 9:26 a.m. and the facility. For on 2/26/21, at 9:26 a.m. and percentage a bed hold was us was below that percentage d hold. RN-A stated she was centage requirement. RN-A are issued a bed hold. For on 2/26/21, at 10:07 a.m. and a state of the facility did not offer a bed, they did just take her back. For dated 11/5/2020, at 5:00 ident is currently admitted to or surgery revisitation [sic]. He did hold status. " Indicate of the years of the facility and the stating and to [name of hospital] ED ment]. Resident in agreeance.	F6	25		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET CALEDONIA, MN 55921	<u> </u>	0/2021
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F 625	Continued From pa	ge 42 dated 1/25/2021, at 10:20	F 6	25			
	a.m. included, "Res ED. c/o [complained	dated 1720/2021, at 10.20 ident request to be sent to d of shortness of breath." The ohysician was updated.					
	provided written ber resident representathe hospital, or with transfer. Further revidecuments scanned record failed to provided hold notice was	d lacked evidence that staff d hold notice to the resident or tive at the time of transfer to in 24 hours of emergent view of R2's paper chart, and d into the electronic medical vide evidence that a written is provided. A copy of a bed hospitalization was requested,					
	director of nursing (on 2/26/2021 at 2:00 p.m. DON) indicated she did not of a bed hold in 136's medical pitalizations.					
	[against medical ad included, "Provide r hold policy to the re	vice]) policy dated 2020 notice of the resident's bed esident and representative at as possible, but no later than esfer."					
	9/2011 included, "2 therapeutic leave, the worker will provide responsible party a ln case of emergen or social worker will within twenty-four (2)	s Bed-Hold Policy dated At the time of transfer or the charge nurse or social the resident and/or written copy of the policy. 3. cy transfer, the charge nurse contact the responsible party hours to provide the policy. 4. When the					

PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245499	B. WING			C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	02/	26/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 625	greater for that more Medicare person we pay thirty (30%) of assigned at the time each day of bed-hot the is at ninety-six greater for that more recipient will be offen Medical Assistance hospitalization, and for therapeutic leave below ninety-six (9) facility will offer the a bed-hold, but will eighteen (18 days per year Encoding/Transmith CFR(s): 483.20(f) (1) Separate facility completes facility must encode each resident in the (i) Admission assess (ii) Annual assessm (iii) Significant charriev) Quarterly review (v) A subset of item reentry, discharge, (vi) Background (fais no admission assess \$483.20(f)(2) Transafter a facility compared to the compared to th	six (96) percent occupancy or on th, any private pay or tho requests a bed-hold will the per diem case mix rate to e of transfer or leave, foe old that is requested. 5. When (96) percent occupancy or on th, any Medical Assistant there a bed-hold covered by the for eighteen (18) days per least thirty-six (36) days per year tes. 6. If the occupancy rate is 6) percent for that month the resident or responsible party not require payment for the oper hospitalization or thirty-six for therapeutic leaves. The therapeutic leaves the data processing ding data. Within 7 days after the resident's assessment, a test the following information for the facility: sement. The nent updates are sident's transfer, and death. The test are seen the following information, if there is the following data. Within 7 days after the following information, if there is the following data. Within 7 days are sessions.	F 6			4/14/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245499	B. WING		C 02/26/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLÉTION	
F 640	each resident conta that conforms to sta data dictionaries, a edits defined by CN §483.20(f)(3) Trans 14 days after a faci assessment, a faci encoded, accurate, the CMS System, ii (i)Admission asses (ii) Annual assessm (iii) Significant char (iv) Significant corre (v) Significant corre assessment. (vi) Quarterly review (vii) A subset of iter reentry, discharge, (viii) Background (finitial transmission does not have an a §483.20(f)(4) Data transmit data in the for a State which has by CMS, in the form approved by CMS. This REQUIREMED by: Based on interview facility failed to ens quarterly Minimum for 1 of 3 (R10) rec assessments.	CMS System information for ained in the MDS in a format andard record layouts and nd that passes standardized MS and the State. Smittal requirements. Within lity completes a resident's ity must electronically transmit and complete MDS data to including the following: sment. Indeed, in status assessment, ection of prior full assessment. Section of prior quarterly MV. In the MDS in a formation for a formation in the following: The matter of th	F 640	1. Immediate action(s) taken for resident(s) found to have been affinclude: R10 MDS was completed and acc on 3/1/21. 2. Identification of other residents the potential to be affected was	ected epted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE 425 NORTH BADGER STREE CALEDONIA, MN 55921	, ZIP CODE	2120/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 640	Minimum Data Set completed and sub medical record ider assessment was sign on 1/20 and 1/22/2 successfully submit electronic health re the MDS indicating been submitted. During an interview nurse (RN)-A review and confirmed that completed and commessage that indica successfully submit MDS nurse was resuscessfully submit MDS nurse was resuscessments were should have checker RN-A stated she would be assessments were should have checker RN-A stated she would be assessments were should have checker RN-A stated she would be assessments were should have checker RN-A stated she would be assessments were should have checker RN-A stated she would be assessments were should have checker RN-A stated she would be assessments were should have checker RN-A stated she would be assessment were should have checker RN-A stated she	(MDS) assessment was mitted was on 7/2/2020. R10's atified a quarterly MDS gned by responsible parties 1, however had not been ted and/or transmitted; R10's cord had an error message for that the assessment had not on 2/26/2021, registered wed the R10's MDS records the assessment had been firmed there was an error ated the assessment was not ted. RN-A stated that the sponsible for ensuring the successfully submitted and ed the confirmation reports. Fould re-submit the MDS now. on 2/26/2021, at 2:00 p.m. stated an expectation MDS submitted on time. not provided. 1)-(3) Insive Person-Centered Care	F6	accomplished by: Residents MDS record past 30 days. Two res MDS have potential to 3. Actions taken/syst to reduce the risk of furinclude: The MDS nurse was re 3/25/21 by the DON a Operation Specialist of RAI process/MDS revision fracility has hired a ne starting after April 14, will be in serviced on producing orientation. 4. How the corrective monitored to ensure the recur: DON or designee will a compliance 2x/week for x wk for two months. For the compliance and validate compliance and	idents with open be affected. Items put into place at the control of the control	ee e

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245499	B. WING		02	C / 26/2021
	PROVIDER OR SUPPLIE	ON & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP OF 425 NORTH BADGER STREET CALEDONIA, MN 55921	•	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 655	admission. (ii) Include the minecessary to propincluding, but not (A) Initial goals be (B) Physician ord (C) Dietary orders (D) Therapy serv (E) Social services (F) PASARR recomprehensive of the care plan if the conference of this section of this section (ii) Meets the req (b) of this section of this section). §483.21(a)(3) Thresident and their of the baseline calimited to: (i) The initial goal (ii) A summary of dietary instruction (iii) Any services administered by the comprehensive of the comprehensive the	within 48 hours of a resident's nimum healthcare information perly care for a resident limited to-ased on admission orders. ers. s. ces. es. ormmendation, if applicable. er facility may develop a are plan in place of the baseline omprehensive care planwithin 48 hours of the resident's uirements set forth in paragraph (excepting paragraph (b)(2)(i) are facility must provide the representative with a summary are plan that includes but is not all soft the resident. If the resident's medications and as. and treatments to be the facility and personnel acting acility. Information based on the details asive care plan, as necessary. ENT is not met as evidenced reation, interview, and document	F 6	1. Immediate action(s) ta		
		failed to develop a base line inticoagulant medication for 1 of		resident(s) found to have be include:	een affected	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X3) MI II	TIDI	E CONSTRUCTION	(Y3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION		PLETED
			50.22				
		245499	B. WING				26/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	0.10011
CALEDO	AUA DELLA DULITATION	U O DETIDEMENT CENTED		42	25 NORTH BADGER STREET		
CALEDO	NIA REHABILITATION	N & RETIREMENT CENTER		С	ALEDONIA, MN 55921		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLÉTION DATE
					DEFICIENCY)		
F 655	Continued From pa	_	F6	355			
		who had a history of side			R139 care plan was updated 2/26/	21 for	
		ulant. In addition, the facility			at risk for abnormal bleeding,		
		baseline care plan for a			spontaneous bleeding, potential		
		had been identified upon			hemorrhage and/or increased/easy	/	
		3 residents (R138) reviewed			bruising r/t taking anticoagulant. 2. Identification of other residents	hoving	
	for pressure ulcers.	•			the potential to be affected was	naving	
	Findings include				accomplished by:		
	agoo.a.ao				Current resident records audit for t	he past	
	R139				30 days to ensure that a comprehe		
	During an interview	on 2/22/2021, at 3:30 p.m.			care plan was implemented with al	I	
	R139 sat in his bed	I, R139 was observed to have			required elements of the individual		
		urple/blueish/yellowish bruise			resident needs.		
		arm. R139 stated he was just			Actions taken/systems put into		
		lity a couple of days ago,			to reduce the risk of future occurre	nce	
		had been there since			include:		
		cility, did not know how he got			Licensed nursing staff will be in-se		
		m, but had just starting taking			on the Baseline care plan process		
		uring hospitalization because			requirements by April 14, 2021.Lic		
		to. R139 stated he was taking			nurses starting after April 14, 2021 in serviced during orientation on the		
		use he had atrial fibrillation. d quit taking it a couple of			process.	13	
		ne developed a blister on his			DON/designee will validate in first	24	
		stop bleeding, and every time			hours, baseline care plan meeting	- •	
		lood was present. R139 stated			scheduled.		
		on to the facility every time he			DON/designee will validate 48 hou	r	
		re is a little blood again just			baseline care plan complete with		
		ast time. R139 stated an			diagnosis related interventions.		
		ff were aware of his bleeding			4. How the corrective action(s) w		
		s not asked by the staff if he			monitored to ensure the practice w	ill not	
	had a history of ble	eding while on anticoagulants.			recur:		
	D4001 A : : :				DON or designee will audit care plant		
		Record, indicated R139 had			2x/week for one month then 1 x wh		
		ne facility on 2/20/2021, with			two months. Results of finding will		
		uded atrial flutter. R139's list			reviewed in QAPI monthly to valida	ate	
		ot identify that R139 had a			compliance after 3 months.		
	diagnoses of atrial	IIDI III AUUT					
	İ		l .		I		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		42	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH BADGER STREET ALEDONIA, MN 55921	1 02.7	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	R139's physician or the risk of stroke ar (mg) by mouth in the (order start date 2/2 R139's care plan ar not identify R139 w medication and/or whad a history of bleet therapy. R139's record lacked monitored for bleed bruise on his right use facility staff. During an interview practical nurse (LPI of R139's bleeding resident was on an monitoring for bruis LPN-B indicated and blew his nose blood During an interview director of nursing (plan and confirmed the anticoagulant. It unawareness of R1 DON indicated upon have been asked at medication in order monitor and treat. It should have identification in start in the strong of the start in the strong of the strong of R1 DON indicated upon have been asked at medication in order monitor and treat. It should have identification in start in the strong of R1 DON indicated upon have identified the	riders included Xarelto (reduce and blood clots) 20 milligrams be morning for atrial fibrillation (20/21). Ind/or base line care plan did as on an anticoagulant was at risk for bleeding and eding during anticoagulant and eding during anticoagulant (20/21). Ind/or base line care plan did (20/21). Ind/or base line care pl	F6	355			
	During an observati	ion on 2/24/2021, at 1:36 p.m.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CI 425 NORTH BADGE CALEDONIA, MN	R STREET	1 02/1	0,2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTIOI RECTIVE ACTION SHOULD RENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	R138 laid on his bar (NA)-F and NA-G a incontinent brief. Bornot aware of any we bottom. When NA's were no wounds proto have a coccyx we fold open wound the of a nickel. Director room, confirmed the and obtained meas a stage 2=0.5 cm x the left buttock wou that measured 2.5 cdepth <0.1 mm. R138's Admission Fadmitted to the facil diagnoses that incluand schizophrenia. R138's Admit/Read 2/12/2021, section R138 had a pressur assessment did not description of the ull R138's Weekly Wor 2/18/2021, identified ulcer however, did in The assessment incentimeters (cm) x documented. The a include treatment p the ulcer. Although R138's bar	ck in bed. Nursing assistant ssisted the R138 in changing oth NA's indicated they were ounds present on R138's cleaned both stated there esent, however was observed ound and a inner left gluteal at was approximately the size of nursing (DON) entered the presences of both wounds urements; coccyx wound was 1.0 cm x 0.2 cm in depth, and and was a superficial stage 2 cm in circumference with a Record, indicated R138 was lity on 2/12/2021, with auded obesity, diabetes type 2, mit Assessment dated C. Skin Integrity, identified re ulcer to his sacrum. The sinclude any further	F6	55			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	COMPLETED	
		245499	B. WING _		C 02/26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	V==0:=v=
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 658 SS=D	During an interview director of nursing (not a base line care identified the prese identified upon adm should have been in An undated Facility included, It is the pobaseline care plant Along with the base of care that is proving representative in a understood. Services Provided ICFR(s): 483.21(b)(3) Common The services provided by the commustified by: Based on observation of the service of the facility factories of the facility factories of the service of the facility factories of the service of the facility factories of the facility factories of the service of the facility factories of the fa	rity related to a surgical wound he sacral pressure area. Yon 2/25/2021, at 11:41 a.m. YON) confirmed there was e plan or a care plan that nice of the pressure ulcer hission. DON stated the ulcer nicluded on the care plan. Policy Baseline Care Plan policy of the facility to develop a within 48 hours of admission. Plan care plan is a summary ded to the resident and language they can be	F 65	5	
	administration. Finding include: R18's current physi	cian orders included: in) 75/25 suspension 100		R21, medication dose was correct. LPN-A was immediately educated of performing 3 safety checks for each medication administered and education provided for medication administration. In service on correct	n ated on

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 658	subcutaneously in give before breakfar on 2/24/21, at 7:45 (LPN)-A was obser administration. LP resident names on each resident. LPN kwik-pen insulin from after applying the redialed up 45 units. computer on the more resident order agait LPN-A stated the factor computer for ever to check the orders computer prior to a LPN-A administere moved on to the nemotication. R33's current phys Novolog 100 unit/m subcutaneously with hold if BS<80 (bloof addition to sliding section 100 unit/ml. Inject 151-200=3, 201-25301-400=10. Notification was that morning; removed R33's Normedication cart and medication cart and medication cart and medication cart and medication cart and size of the subcutaneous subcutaneous on 2/24/21, at 7:52 assistant (NA) what was that morning; removed R33's Normedication cart and size of the subcutaneous of the subcutan	illililiter). Inject 45 units in the morning for diabetes, ast. 5 a.m. licensed practical nurse ved preparing R18's insulin for N-A had a sheet of paper with it and insulin dosages for N-A removed R18's Humalog om the medication cart and needle and priming the pen, LPN-A did not have a edication cart to check the nst the label on the pen. acility didn't have enough y medication cart so she had a ahead of time in the dministering the insulin. In the insulin to R18, then ext resident to administer ich meals for hyperglycemia and sugar less than 80). Give in its cale insulin. Novolog solution as per sliding scale: if 10=7, 251-300=10, y provider of BS greater than	F 6	process completed on 3/26/21. 2. Identification of other resident the potential to be affected was accomplished by: Residents receiving a medication the LPN have the potential to be a 3. Actions taken/systems put int to reduce the risk of future occurrinclude: Licensed nursing staff will be in son facilities policy related medicat administration by April 14, 2021.L Nurses hired after April 14-2021 v serviced during orientation on this process. Licensed Nurse will have a medic pass observation completed by A 14,2021. Licensed Nurses hired a 14-2021 will be in serviced during orientation on this process. Licensed Nurse will have a medic pass observation completed biant Facility purchased new laptop for only medication cart. Nurses will trained on that by April 14, 2021. 4. How the corrective action(s) we monitored to ensure the practice vecur: DON or designee will randomly at medication administration 2x/wee one month then 1 x wk for two monitored to reviewed QAPI monthly to validate compliants 3 months.	pass by affected. o place ence erviced ion icensed vill be in oril ation oril ation nually. nurse be will be will not udit LPN k for onths.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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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 PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	confirmed R33's ord sliding scale, which additional units. LF physician order prict though did refer to R21's current physiciacidophilus (a prob G-tube in the mornicacid (vitamin C) giv times a day for sup 25 mg, give one take pulmonary congest 1,000,000 unit/ml, good aday for thrush paint tongue compressor give 500 mg via G-to convulsions, Miravia G-tube in the mornicacid computer prior to good setting up the above stated R21's medication room, and checked R21's med	der was for 5 units including at a value of 167 would be 3 PN-A did not review R33's or to preparing the insulin	F6	58			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
F 658	during set up and to more appropriate p	o triple check, would be a rocedure and confirmed she	F6	558		
	was performing the could set the nurse. When interviewed of director of nursing (started at the facility the need for a comply the licensed nurse a 3rd computer for expected nursing si when administering. The policy titled, Ac dated 2018, indicate checks for each melabel and compare.	medication administration up for errors. on 2/24/21, at 1:20 p.m. the (DON) stated when she had by 2 weeks prior had identified outer on the med cart utilized se, and supplied nursing with that cart. DON confirmed she taff to utilize that computer				
F 661 SS=D	the MAR when prepadministration. Reather MAR just prior to Discharge Summar CFR(s): 483.21(c)(2) Discharge Summar CFR(s): 483.21(c)(2) Discharge Summar Manager Manage	paring the medication for ad the label and compare to so administration. y 2)(i)-(iv) harge Summary hticipates discharge, a resident large summary that includes, the following: of the resident's stay that limited to, diagnoses, course or therapy, and pertinent lab,	F 6	061		4/14/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 661	medications with the medications (both over-the-counter). (iv) A post-discharge developed with the and, with the residure presentative(s), adjust to his or her post-discharge plathe individual plans that have been madere and any post-non-medical service. This REQUIREME by: Based on interview facility failed to condischarge summar reviewed for discharge reviewed for discharge summar reviewed for discharge include: R36's face sheet, if facility of 11/30/20 hypertension (high history of diabetic facility of 11/30/20 hypertension (high history of diabetic facility failed to company that we company that we company that we discharge instruction and verbal education reviewing the medit (MAR) and treatments.	of all pre-discharge ne resident's post-discharge prescribed and ge plan of care that is a participation of the resident ent's consent, the resident which will assist the resident to new living environment. The n of care must indicate where s to reside, any arrangements de for the resident's follow up discharge medical and res. NT is not met as evidenced w and document review the nplete a comprehensive y for 1 of 1 resident (R36)	F 66	1. Immediate action(s) taken resident(s) found to have beer include: R36 discharged from facility 12 2. Identification of other resid the potential to be affected wa accomplished by: Audit completed of current res past 30 days for discharge. No residents found to be affected. 3. Actions taken/systems put to reduce the risk of future occinclude: Licensed nursing staff will be in on facility policy r/t discharge/t comprehensive summary by A 2021. Licensed Nurses hired a 14-2021 will be in serviced dur orientation on this process. DON/Designee will review residented a planned discharge their comprehensive comprehensive summary by A 2021 will be in serviced durorientation on this process.	a affected 2/16/20. Idents having s idents for other into place currence a serviced ransfer pril 14, after April ring idents with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245499	B. WING		02/26	5/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	, 32/23	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 661	not include copies of R36's discharge inscognitive patterns, behavior patterns, behavior patterns, continence, diagno condition, and active During an interview receptionist stated R36's signed dischinformation provide the facility. During an interview director of nursing discharge instruction patterns, communic patterns, communic patterns, psychoso diagnosis and heal and activity pursuit management complete. The DON instructions did not regulation. The Transfer and E AMA[against medic included, Anticipat initiated by the resion obtain physician's discharge and instructions of the in relevant sections of nurse caring for the	the resident or family and did of medications, MAR, or TAR. structions did not include communication, vision, mood osychosocial well-being, sis and health conditions, skin rity pursuit. Yon 2/25/21, at 8:43 a.m. the was unable to find a copy of arge instructions and do to R36 upon discharge from the condition, vision, mood behavior cial well-being, continence, the conditions, skin condition, and was in the process of the summary for the facility to a verified R36's discharge meet the requirements of the condition of the condit	F 66	post discharge plan in the morning meeting prior to discharge for outs care areas. How the corrective action(s) will be monitored to ensure the practice verecur: DON/Designee will audit resident residents record 2x/week for one then 1 x wk for two months for concomprehensive post discharge plat (Recapitulation of stay). Results of finding will be reviewed QAPI monthly and compliance variafter 3 months.	standing be will not month mpleted anning	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245499	B. WING _			C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	but not limited to the A recap of the residential diagnoses, course and pertinent lab raresults. A final summary of Reconciliation of all with the resident's processed and post discharge ple with the participation resident's represent resident to adjust to environment. Orientation for transprovided and docur orderly transfer or ofform and manner that understand. Depend this orientation may member of the interest with transport new facility and any needed. The comprehensive shall contain the reand desired outcom with the discharge. Supporting docume of the resident's or verbal or written not facility, a discharge discussions with the representative.	re following: lent's stay that includes of illness/treatment or therapy. adiology and consultation the resident's status. I pre-discharge medications oost-discharge medications and over the counter.) an of care that is developed on of the resident, and the tative(s) which will assist the o his or her new living sfer or Discharge must be mented to ensure safe and discharge from the facility, in a nat the resident can ding on the circumstances, or be provided by various	F 66			<i>A/1A/</i> 21
	Quality of Care CFR(s): 483.25		F 68	4		4/14/21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245499	B. WING		02/2	; :6/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	applies to all treatmer facility residents. But assessment of a restrict that residents received accordance with proposition practice, the compressive plan, and the interest that residents (Respectively). Based on observative review the facility factor that facility factor that the facility factor factor for the facility factor for facility factor for the facility factor for the facility factor for facility factor for the facility factor for the facility factor for the facility factor for facility factor factor factor facility factor facility factor fa	care fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered	F 684	1. Immediate action(s) taken for tresident(s) found to have been affer include: R139 skin is being monitored. DON RN-A did a skin assessment imme 2/23/21 and documented the PU firon the lower extremities. MD was non 2/23/21 regarding skin assessmindings, physician orders followed indicated. R2 Fluid intake monitoring medicate administration MAR was corrected include breakdown of resident fluid restriction per 24 hours. R2 Edema assessments completed 3/26/21. LPN-B was verbally educated on requirements to complete full body assessments on admissions on 2/2 Formal in service was completed 3 RN-A was verbally educated on requirements to complete full body assessments on admissions on 2/2 Formal in service was completed 3 2. Identification of other residents the potential to be affected was accomplished by:	lected N and diately indings notified nent as ito ito d on skin 24/21. //26/21.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C 26/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	•		
CALEDO	NIA DELIADII ITATIO	N & RETIREMENT CENTER		425 NORTH BADGER STR	EET		
CALEDO	NIA KEHABILITATIO	N & RETIREMENT CENTER		CALEDONIA, MN 55921	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 684	Continued From pa	age 58	F 6	84			
	of the left foot that was asked if staff I feet, in response F looked at the wour any other skin con R139's Admission been admitted to the diagnoses of diabeth chronic obstructive morbid obesity. R139's hospital dis 2/19/2021, indicate the hospital on 2/8 2/19/2021. The sure diagnoses of diabeth congestive heart fathe facility's list of summary identified treatment of, howehad ulcerations to R139's Admit/Readm	Record, indicated R139 had he facility on 2/20/2021, with etes type 2, Fournier gangrene, a pulmonary disease, and scharge summary dated ed R139 had been admitted to /2021 and discharged on mmary also included etic peripheral neuropathy and eailure that was not included on diagnoses. The discharge of the groin wound and the ever did not identify that R139 his feet.		days. Skin assessm time of admission. Five other current restrictions. Current include 24-hour bre Current residents we dema monitoring wother failures to more of the reduce the risk of include: Licensed nursing st on skin assessment documentation upon 14, 2021. Licensed April 14-2021 will be orientation on this purchast on fluid resprocess. This is includered breakdown on MAR April 14-2021. Licensed TMAs hired after April 14-2021.	t fluid restriction orders akdown of fluid intake. with MD orders for were reviewed. No nitor edema noted. ystems put into place future occurrence that and PU findings and n admission by April Nurses hired after e in serviced during process. The TMA's will be instriction resident luding Fluid Restriction and Care Plan by used Nurses and pril 14-2021 will be instriction to the control of the c		
	During an observa 2/23/2021, at 8:52 registered nurse (F	titled Skin Integrity, did not ed skin integrity to R139's feet. tion and interview on a.m. R139 laid in bed, RN)-A and director of nursing nt in the room to change the		serviced during orie process. DON/Designee will restriction order, ne orders during the fo clinical meeting. The facility now place	review new fluid w edema monitoring llowing mornings		
	dressing to R139's dressing change be to leave the room, look at R139's feet sock exposing a garage.	s groin. At the completion of the oth RN-A and DON were going surveyor requested RN-A to t. RN-A took off R139's right auze bandage wrapped around RN-A donned gloves, removed		changes r/t to skin a monitoring notificati report.	assessment, edema		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245499	B. WING			26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 684	bottom of R139's for wound; stated it was cm x 0.1 cm in dep left sock, there was no dressings were wound on the great depth of 0.2 cm. Robserved to be veright R139 stated he had them at home. R139's correspond 2/23/2021, at 9:35 of wound clinic]- up toe, and right plant assessments comphydrofera blue and plantar. Keep left g Change dressing qualicensed practical morked on 2/20/20 to R139's groin how about the impaired During an interview nursing assistant (I cares to R139 the I worked on 2/20/21, and and in his groin stated on 2/20/21, needed help with a so she had not seed did not ask R139 if	kposed the ulceration on the bot. RN-A measured the is 1.0 centimeters (cm) x 2.0 th. RN-A then removed R139's an area on the big toe with present. RN-A measured the toe; 2.9 cm x 1 cm with of 139's lower extremities were y dry with thick scaley skin. It been putting vaseline on ing progress note dated a.m. included "Contact [name botated on dry feet, left great ar foot. Initial wound bleted. Orders recieved for cover q [every] 3 days to right reat toe clean and dry. 3 days. Vaseline to feet." on 2/23/2021, at 3:55 p.m. hurse (LPN)-B stated he had 21, had changed the dressing vever did not know anything skin integrity to R139's feet. on 2/23/2021, at 3:59 p.m. NA)-E stated she had provided ast couple of days and had when R139 was admitted. as only aware that R139 had a and nowhere else. NA-E she had asked what R139 nd he wanted his socks left on n his feet. NA-E stated she she could inspect his feet for rity and did not ask if he had	F 684	monitored to ensure the practice recur: DON or designee will audit for the compliance 2x/week for one money was for two months. Results of will be reviewed in QAPI monthly validate compliance after 3 money mone	IDS nth then 1 finding y to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		42	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH BADGER STREET ALEDONIA, MN 55921	l OZI	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	any sores. During an interview RN-A stated she had of the wounds on R During an interview DON stated she had admission, howeve nurse she had not audit and asked that stated she did not f had assumed that i stated she had not wounds to R139's f expected that a full upon admission, ar	on 2/23/2021, at 4:47 p.m. ad not previously been aware 139's feet before today. on 2/23/2021, at 5:06 p.m. d completed R139's reported to the evening shift completed the entire body at the nurse complete it. DON ollow-up with the nurse and thad been completed. DON been previously aware of the eet. DON stated it was body audit be completed ad indicated staff should be independent residents to	F 6	84			
	R2 sat in his wheel down in the dependence of the down in th	ion on 2/26/21, at 8:42 a.m. chair in his room with his legs dent position. R2 had tubi s, both legs observed to be eright worse than the left. R2 1.5 liter fluid restriction, and en following. R2 stated that the er and their was water in the elevated his legs at night to ng, and were up in the air from m. R2 stated staff weighed st and staff checked for //.					

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		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, 425 NORTH BADO CALEDONIA, M		1 02.	-0/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULI FERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	hypertensive heart with heart failure, and R2's scheduled (PF assessment dated not have cognitive in was not administered. R2's physician order and pailing weight for eduction and compared to the properties of	and chronic kidney disease and shortness of breath. PS) Minimum Data Set 1/13/2021, identified R2 did impairment and indicated R2 and diuretic medications. Pers included: ema (Start date 12/5/2020) 00 milliliters (ml) per day (start in the morning off at bedtime for 2/17/2020) (iic) 2.5 milligrams (mg) every any, Friday for fluid restriction extension	F 6	84			
		hard cast removed and cam					

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		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		425 NO	ADDRESS, CITY, STATE, ZIP CODE RTH BADGER STREET DONIA, MN 55921	1 02//	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	boot applied to his may be related to the even and unlabored lower edema 1+. To extremities and left 9:17 p.m. indicated nurse several fluid on the right leg were R2's progress note pitting edema to low Left arm edema president of Listening to lungs wright upper lungs." A a.m. included, "Resanymore bloody phe continue to monitor condition and upda R2's weight change R2 triggered for we R2's progress note included "lungs has upper side." Daily weights identified weights and indicat same time every date.	right foot, and weight variance he new device. Breath sounds d lung sounds clear. Bilateral abigrips on both lower arm. A subsequent note at at 6:00 p.m. R2 had showed filled blister and open wounds e the cast was. dated 2/20/21, included " +3 wer legs and feet bilaterally. Esent from elbow to fingers. dated 2/21/21, at 2:01 a.m. coughing 0100 [sic] blood. Wheezing could be heard in his A subsequent note at 5:50 sident die [sic] not cough out legm, vitals stable will resident for change of the primary provider. In note dated 2/21/21, at 8:00 p.m. a bit of wheezing in the left fied fluctuations in R2's ed R2 was not weighed at the ay. m 262 pounds lbs. m 265.2 n264.4 n265.2 n264.2	F 6	84			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245499	B. WING			C 26/2021
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		
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F 684	evaluation of fluid in orders and the care R2's Fluid Intake reto 2/22/21, the reco of fluid intake, and evaluation of 24 ho identify fluid volume Based on the docudetermined if R2's 2 followed according On 2/10/21, breakfa applicable", for lunch ml. On 2/11/21, breakfa lunch 200 ml, and odocumented as "no On 2/12/21, breakfa dinner- was left bla On 2/13/21, breakfa dinner documented On 2/15/21, breakfa dinner was left blan On 2/15/21, no fluid day	m261.8 m266.0 m269.2 m266.4 n266.8 n265.4 evidence of monitoring and ntake according to physician e plan. cord was reviewed from 2/10 and lacked consistent recording the record lacked evidence of the	F 6	84		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	TE SURVEY MPLETED
		245499	B. WING			C / 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	On 2/19/21, breakfaml, dinner was left On 2/20/21, breakfand dinner intake won 2/21/21, breakfaml, dinner 180 ml. During an interview registered nurse (Redocumenting fluid in administration reconsin R2's record where documented and standard determined how much on a daily basis. Rist be a good person to the computer after the computer	was recorded for each meal. ast was left blank, lunch 240 blank ast was left blank, both lunch was 240 ml ast was left blank, lunch 120 on 2/24/2021, at 2:31 p.m. lN)-B stated nurses are intake on the TAR's [treatment rd]. RN-B reviewed the areas	F6	84		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET ALEDONIA, MN 55921	U	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	people tracked that During an interview trained medication when she passed in the amount of fluid tracked fluid intake. During an interview RN-A stated if a reserstriction, the dietic fluid was divided overesident could have allowed for medicat were supposed to the resident was recoutside of what they "I don't believe that the 24 hour totals, can't confirm that." During an interview director of nursing (intakes and stated if way fluid intakes we evaluation of the intercompleted. During an interview certified dietary mand housekeepings if a resident is on fluid a sheet of paper. Consupposed to record the computer. CDM who was evaluating CDM stated an una	on 2/26/2021, at 8:51 a.m. assistant (TMA)-A stated nedications she did not record intake and dietary staff on 2/26/2021, 9:18 a.m. sident was on a fluid cian determined how much wer each meal, how much the in his room, and the amount ion passes. RN-A stated NA's communicate to the nurse if questing additional fluids were provided. RN-A stated there is someone evaluating our dietician may go in but I on 2/25/2021, at 11:22 a.m. DON) reviewed R2's fluid the facility did not have a solid ere being documented and takes was not being on 2/26/2021, at 9:39 a.m. nager (CDM) stated dietary staff pass water twice per day, aid restriction it is identified on DM stated dietary staff are fluid intake after each meal in I stated an unawareness of 24-hour daily fluid intakes.	F	584			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

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		245499	B. WING		02	C / 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 684	meals such as fluid during medication president requests. Facility policy Press Breakdown-Clinical included 2. The nurse shall of the following: Full a including location, sidepth, presence of Current treatments 3. The staff will exalpha admission for ulcers Facility policies for heart failure/fluid in managemet were reprovided. Treatment/Svcs to CCFR(s): 483.25(b)(1) Pressure ulcers and pressure ulcers and ulcers unless the indemonstrates that the facility (ii) A resident with president requirements.	s given during activities, passes, or extra amounts the sure Ulcers/Skin Protocal dated 2/2014 descrbe and docuemtn reprot assessment of pressure sore size, stage, length, width, and exudates or necrotic tissue, including support surfaces, mine the skin of a new ations or alterations in skin. management of congestive take monitoring/edema equested and were not Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. brehensive assessment of a	F 6			4/14/21
	promote healing, pr new ulcers from de	andards of practice, to revent infection and prevent veloping. NT is not met as evidenced				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			SURVEY PLETED		
		245499	B. WING				26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		425 N	ET ADDRESS, CITY, STATE, ZIP CODE ORTH BADGER STREET EDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	review the facility fa assess, monitor, ar ulcer for 1 of 3 resi pressure ulcers. Findings include During an observat R138 laid on his ba (NA)-F and NA-G a incontinent brief. B not aware of any w bottom. When NA's were no wounds produtocks were observed a coccyx wou open wound that w nickel. R138 denier related to the impanursing (DON) enterpresences of both measurements; DC stage 2- 0.5 cm x 1 the left buttock wou that measured 2.5 depth <0.1 mm. R138's Admission admitted to the facilitation and schizophrenia. R138's Admit/Reac 2/12/2021, section	tion, interview, and document alled to comprehensively and treat a worsening pressure dents (R138) reviewed for dents (R138) with changing oth NA's indicated they were ounds present on R138's reved, R138 was observed to and and a inner left gluteal fold as approximately the size of a dination dents and obtained dents are dents and und was a superficial stage 2 cm in circumference with a decord, indicated R138 was ality on 2/12/2021, with unded obesity, diabetes type 2, dents described described dents are detected as a pressure ulcer to his	F 6	1 reining R (N Kare (L in sk 2. th ac Ci re ariding 3. to ining A fa fa the hiin se production of the second control of the second c	. Immediate action(s) taken for sident(s) found to have been affectude: 138 was discharged on 3/16/202 IA)-F was in serviced on resident ardex and the repositioning need sident. IA)-G was in serviced on resident ardex and the repositioning need sident. PN)-A was in serviced on how to the electronic health record a resident epotential to be affected was accomplished by: urrent resident with pressure ulcoviewed for appropriate measurer and care planning. No others at risentified. Actions taken/systems put into reduce the risk of future occurred clude: ursing staff will be in serviced on ad a resident Kardex for loss of stegrity and re position requireme for position requireme oril 14-2021 Facility nursing staff ter April 14-2021will be in serviced oril 14-2021on how to locate and resident's skin status in the elected after April 14-2021 will be in serviced oril 14-2021on how to locate and resident's skin status in the elected after April 14-2021 will be in serviced after April 14-2021 will be in serviced original after April 14-2021 will be in serviced original after April 14-2021 will be in serviced after April 14-2021 will be in serviced after April 14-2021 will be in serviced original after April 14-2021 will be in serviced a	ected 21. ts s of a ts s of a locate sident's s having ers ments sk p place how to skin nts by hired ed d by update cronic urses	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245499	B. WING			26/ 2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 686	plan dated 2/12/20 impaired skin integ it did not address the R138's activities of 2/15/2021, indicate assist for toileting a mobility, R138 coul bowel and bladder 2/15/2021, included hours and assist with Provide pericare af R138's diabetic car all of body for breal as ordered by doctor "Monitor/document needed] for s/sx [si any open areas." R138's Weekly Wo 2/18/2021, identified ulcer however, did The assessment in centimeters (cm) x documented. The assimplemented include a specific transcription to treat. R138's progress not p.m. included, "a sperson]. Butt assess received to clean cosaline]. Pat dry. Ap Cover with 2 x 2 [gaper day. Notify proventions of the skin wound states and saline] and ship person.	aseline care plan and/or care 21 identified that R138 had rity related to a surgical wound ne sacral pressure area. daily living care plan dated d R138 required one staff and transfers, and bed d reposition himself. R138's incontinence care plan dated d "check resident every two th toileting as needed. ter each incontinent episode." e plan directed staff to "Check is in skin and treat promptly	F 686	complete measurements, Baselin plan that includes location and individualized reposition needs do next morning clinical meeting. 4. How the corrective action(s) monitored to ensure the practice recur: DON/Designee will audit new address for one month then 1 x v two months for appropriate documentation of loss of skin into Baseline care plans and reposition schedule. Results of finding will be reviewed QAPI monthly and compliance variafter 3 months.	will be will not missions vk for egrity, oning	

	DI AN OF CORRECTION . IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		425	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH BADGER STREET ALEDONIA, MN 55921	1 02/	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	"sacral midline- 0.1 visualize the base of observed from wou practitioner]. Reside was not authored be measured the wour not consistent with DON at the time the Weekly Wound Ass 4:16 p.m. did not in assessment and on pressure 0.2 x 0.5 [pressure area was assessment. During an observat R138 laid on his baselevated. During an interview 2/24/2021, at 8:00 at the same position. (LPN)-A said R138 ulcers on his bottom During an observat R138 continued to lunidentified nursing room and assisted breakfast. During a 9:00 a.m. the NA has continued to be in to During an interview 2/24/2021, at 11:55 back with the head	x 0.1 x 0.2 cm- unable to of wound. No drainage and. Special visit for NP [nurse ent denies pain." The note by the DON who physically and; the measurements were measurements stated by the end wound was assessed. essment dated 2/24/2021, at clude the sacral ulcer ally identified "left buttock com]." Stage of the left buttock not identified on the same did not have any pressure and observation on a.m. R138 continued to lay in Licensed practical nurse did not have any pressure and in the same position, and assistant (NA) entered the R138 with eating his subsequent observation at add left the room, and R138	F6	886			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C 02/26/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE 425 NORTH BADGER STREE CALEDONIA, MN 55921		V-1-0/-1-0-1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED DEFICII	ACTION SHOULD BE TO THE APPROPRIAT	(X5) COMPLETION DATE	
F 686	and had not reposit NA-F stated R138 v not done anything v assisting him with lik know when he need today had not put of During an interview NA-F stated her and between 6:00 a.m. wet and had not put we (NA-F and NA-C 11:15-11:30 a.m., b well that morning; NA's both confirmed and 11:15-11:30, R and/or offered repoput on his call light. really long time aparasked how often R1 asked how often R1 repositioned, neither often R138 should light. During an interview director of nursing (record, confirmed the often R138 should light. Don confirmed the often R138 should light. The plan of the plan of the plan of the confirmed system in place to confirm the system the system than th	ioned R138 before or after. wasn't feeling well today, had with him prior to or after unch, and stated he let us ded something, however oddly n his light at all so far. on 2/24/2021, at 1:40 p.m. d NA-G changed R138 and 7:00 a.m., he had been t on his call light. NA-F stated G) didn't get him dressed until ecause he hadn't been feeling NA's stated R138 was wet. d between the times of 6-7:00 138 had not been repositioned sitioning because he had not NA-A stated, "I know that's a art but we try our best." When 138 was supposed to be er aide could articulate how	F 6	886			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245499	B. WING			C / 26/2021
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 686	Facility policy Press dated 2/2014 include procedure is to procedure assessment: 2. Sk assessed for the processure ulcers on frequently if indicate perform routine skii b) nurses are to be changes are identificisk can develop a phours of onset of proceds to be identificimplemented prompressure ulcers. The	sure Ulcer Risk Assessment led, the purpose of this vide guidelines for the entification of residents at risk	F 6	86		
F 689 SS=D	included: The nurse shall desthe following: Full a including location, s depth, presence of Current treatments. The staff will exami admission for ulcer. Free of Accident Ha CFR(s): 483.25(d) (S483.25(d) Accider The facility must en §483.25(d)(1) The staff will exami admission for ulcer.	Protocol dated 2/2014 scribe and document report ssessment of pressure sore size, stage, length, width, and exudates or necrotic tissue. including support surfaces. ne the skin of a new ations or alterations in skin. azards/Supervision/Devices 1)(2)	F 6	89		4/14/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING		02/2	26/2021	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	02/2	20/2021	
041 500	AUA DELLABULITATION	L & DETIDEMENT OFNIED		425 NORTH BADGER STREET			
CALEDO	NIA REHABILITATION	I & RETIREMENT CENTER		CALEDONIA, MN 55921			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 689	Continued From pa	ge 72	F 6	89			
	supervision and assaccidents. This REQUIREMENT by: Based on observatoreview, the facility frassess each fall, iddetermine the reasopotential effective in risk for future falls frace for fall frace for fall frace for fall falls frace for falls fall frace for falls frace	d on 02/23/21, at 3:32 p.m. f her bed, gripper socks, tray		 Immediate action(s) taken for resident(s) found to have been affinclude: R137 Risk assessment completed 2/24/21, new interventions initiate appropriate. R24 Risk assessment completed 2/24/21, new interventions initiate appropriate. Identification of other resident the potential to be affected was accomplished by: Audit completed of current resider past 30 days for falls. Twelve other residents found to be potentially a review of record noted. Intervention in place. Actions taken/systems put into reduce the risk of future occurre include: Licensed staff educated on new in program, process, and expectation including root cause analysis, caufactors, and interventions by April 2021. Nursing staff hired after April 14-2021 will be in serviced during orientation on this process. Facility initiated new process of 	ected I on d as on d as s having hts for er effected, ons put o place ence hcident n se 14, il		
	reach and encourag	esident's call light is within ge the resident to use it for ed. The resident needs		completing fall investigation form effected immediate intervention. Find Nursing staff will be in serviced or	acility		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245499	B. WING			26/ 2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	Follow facility fall prevaluate and treat an eeded]." R137's progress not p.m. included, "Resonursing assistant] an inght "when it was approached her stabathroom at 0330-C Left then fell to the and back to bed not Now c/o [complaini of back. No rednesstable]. Admits have to call for assist wit will pee my pants". call right away for stable investigation or meeting review of the During an interview director of nursing to been made aware overified there was rinterdisciplinary teastated the fall interval to call for assinotes. The DON version the process of the pool	all requests for assistance. Protocol. Pt [Physical Therapy] as ordered or PRN [as or PRN [as ordered or PRN [as ordered or PRN	F 689	4. How the corrective action(s) was monitored to ensure the practice vecur: DON or designee will audit for fall comprehensive assessment of ea 2/week for one month then 1 x whomoths. Results of finding will be reviewed in QAPI monthly to valid compliance after 3 months.	will be will not ls and a ach fall c for two	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	<u>_</u>	<u> </u>	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD E		(X5) COMPLETION DATE
F 689	LPN-A stated wher the person who finfall investigation. L determine the root and family membe a progress note receverything you have told the CNA (certifus between 11:30 a.m. during the night. The assistant) reported there and asked he stated R137 told must be the opposite was instructed R137 to have a fall to let stated she did not form. LPN-A stated happened during the protocol was for stated she did not about the fall. LPN when this was goin not quite sure how probably should haverified did not follofalls and stated the	on 02/24/21, at 1:15 p.m. In there is an unwitnessed fall, do the resident completes a PN-A stated we need to try to cause of the fall. The provider of a rare contacted, and you make garding the incident regarding of edone. LPN-A stated R137 fied nursing assistant) she fell in and 12:00 p.m. that she fell in the CNA (certified nursing it to LPN-A and she went in the east dark, she stood up started then she tried to stand up, she had got up to go to the as dark, she stood up started then she tried to stand up, she had got up to go to the as dark, she stood up started then she tried to stand up, she had got up to go to the as dark, she stood up started then she tried to stand up, she had got up to go to the as dark, she stood up started then she tried to stand up, she had all for assist and if she did had aff know right away. LPN-A fill out the fall investigation if the night and she was not sure what or something like that. LPN-A notify the provider or the family and she was not sure what or something like that. LPN-A notify the provider or the family and stated she was also to handle it. LPN-A stated she have filled out the form. LPN-A ow the facility procedure for at this has never happened to omebody stated they had fallen	F 6	89			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245499	B. WING				C 26/2021	
	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		425 NORTH B	RESS, CITY, STATE, ZIP CODE BADGER STREET A, MN 55921	1 02.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTIO CH CORRECTIVE ACTION SHOULE S-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 689	During an observat R24 laid in bed with R24's call light was bed was in low posthe bed. R24's when of the mat furthest of the	ion on 2/22/2021, at 3:04 p.m. his eyes closed and snoring. laced around bed grab bar, ition, and fall mat was next to elchair was close to the edge from the bed. ecord, included diagnoses of et, lack of coordination, tered mental status, cataract, ivioral disturbance, and it and mobility. num Data Set (MDS) 1/6/2021, indicated R24 had pairment and delusions. The required extensive e staff for bed mobility,	F 6	89				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C 02/26/2021	
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP 425 NORTH BADGER STREET CALEDONIA, MN 55921	CODE	021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 689	-floor mat at bedsidneeds meaningful potential for falls which distraction. Offer to date 2/30/2019)non-skid strips in filloor start date 10/2-Offer toileting upon and after meals and resident unattended 3/17/2020)Place resident's which will be distributed in lowest position date (1/3/2020)Bed in lowest position date (1/3/2020)Bed in lowest position date (1/3/2020)Facility incident repp.m. included R24's was documented at you kids to come hereferring to staff as Immediate Action Tosigns obtained and light within reach, eassistance, supervithroughout the shiff remainder of the forcausal factors, root interventions was be R24's correspondin 11/20/2020, at 2:56 noted on floor mat a assessed resident a motion] intact VSS normal limits], alert	e (start date 2/12/2020) activities that minimize the nile providing diversion and lay down after activities (start ront of resident recliner on the 1/2019) a rising, before bed, before dat 10 p.m. Do not leave don the toilet (start date the leave don't he toilet (start date the sin't in the chair to bed, call necouraged to use/request for sion measures taken that addresses potential cause, and ongoing	F6	589			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		42	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH BADGER STREET ALEDONIA, MN 55921	1 02	-0/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	placed with easy re light, at this time be of physician] and far R24's record did no root cause analysis interdisciplinary tear During an interview nursing assistant (N for falls. NA-D indic between good days indicated R24 had cand would not use I anticipate his needs had his sleepy days check on him at lear R24's bed needed to the floor mat down, wheelchair near the case R24 did get up walk to his chair. During an interview director of nursing (and incident report report lacked an invidetermination of roor review/revision of the those tasks should	ach, resident able to use call d lowered to the floor, [name	F 6	689			
	his call light was no for him because he remember to use th Facility policy Fall F 12/2007 included, T	t an appropriate intervention did not consistently e call light. Risk Assessment dated					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245499	B. WING _			C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	, 02.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	consultant pharmac will seek to identify	ge 78 cist, therapy staff, and others, and document resident risk	F 68	99		
	between the onset episodes) and rece medication regimer. The assessment da underlying medical the risk for injury from The staff with suppose will evaluate function that may increase for The staff will seek the factors that may collighting and room later to identify and address and interventions to consequences of rismodifiable. Dialysis CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must en require dialysis received with professional structure of the residents' goals. This REQUIREMENT by: Based on observative review the facility fasystems for monitor residents (R13 and failed to ensure the	ata shall be used to identify conditions that may increase om falls. ort of the attending physician onal and psychological factors all risk, o identify environmental ntribute to falling, such as ayout. ding physician will collaborate ress modifiable fall risk factors try to minimize the sk factors that are not essentially the services, consistent andards of practice, the son-centered care plan, and	F 69	1. Immediate action(s) taken for resident(s) found to have been affinctude: R 13 MDS was corrected on 3/18/2 include cognition status. R 13 Medication administration recognition recognit	ected 21 to	4/14/21

PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY PLETED
	245499	B. WING		1	26/2021
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION	& RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 425 NORTH BADGER STREET		
			CALEDONIA, MN 55921		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
when the dialysis sit residents (R13) revidents (R13) revidents (R13) revidents (R13's Admission Relead stage renal disedialysis, and essential R13's annual Minimal assessment dated 1 R13's cognition. The staff assistance for a required dialysis. R13's nutritional cardincluded record and weigh resident per faweights. The hydratic identified R13 was a potential fluid deficit stools; associated in educate resident/famintake, offer drinks densure all beverages diet/fluid restrictions requirements, monitiand monitor and dooper facility policy. R1 hemodialysis dated following: Check and access site. Docume as ordered, palpate use stethoscope to blood flow through the dialysis on Monday,	d to notify the dialysis center to was bleeding for 1 of 2 ewed for dialysis. cord, included diagnosis of ease, dependence on renalital hypertension. um Data Set (MDS) 2/6/2020, did not identify eMDS indicated R13 required activities of daily living and e plan dated 12/1/2021, monitor intake daily, and acility protocol and monitor ion care plan dated 1/7/2020, at risk for dehydration or related to regular loose atterventions included, mily on importance of fluid luring one to one visits, as offered comply with and consistency or for signs of dehydration, cument intake and output as	F6	(MAR) and Care Plan was conclude breakdown of per 24-residents fluid restriction on 3 R 23 Medication administration (MAR) and Care Plan was conclude breakdown of per 24-residents fluid restriction on 3 LPN-A was in serviced on the requirement to notify the Dial of any bleeding to Dialysis sit Dialysis treatment on 3/26/21 2. Identification of other rest the potential to be affected waccomplished by: Facility has residents on Dialysis. 3. Actions taken/systems per to reduce the risk of future of include: Licensed Nurses and TMA's serviced on Facilities Dialysis process. This is including modialysis site, Fluid Restriction on MAR and Care Plan and I post dialysis site bleeding by 14-2021. Licensed Nurses and hired after April 14-2021 will serviced during orientation of process. Facility implemented a new of communication tool for improcommunication between Dialysis center. DON/Designee will review rediction sheet	chour 3/26/21. on record or rected to chour 3/26/21. et lysis Center te post 1. idents having as a no other ut into place ccurrence will be in a resident onitoring of a breakdown Notification of April and TMAs be in an this dialysis oved Facility and sidents et during the cal meeting.	

Facility ID: 00073

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	COM	E SURVEY IPLETED
		245499	B. WING _			C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP C 425 NORTH BADGER STREET CALEDONIA, MN 55921	•	20,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 698	emergency services medical emergency services of bacteremia, septic fistula on right uppoliter fluid restriction hemodialysis [namedialysis [namedialysis [namedialysis [namedialysis emove fist after each "Hb" (signification of the person of the properties	resertion site and contact as and dialysis center. This is a y. Do not leave resident alone ervices arrive. Treport as needed for bleeding, hemorrhage, shock. Resident has an AV er arm, resident is on a 1.5 and resident receives e of dialysis clinic]. The ders included all supplement all supplement and supplement and supplement are the following that bandages after 4 hours and the process of the following that to the ER every evening and the ER every evening are the following that	F 69	recur: DON/Designee will comple 2 x week for one month the two months for validation o fluid restriction documentat Results of finding will be re QAPI monthly and complia after 3 months.	en 1 x wk for f appropriate tion. viewed in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245499	B. WING _			C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 698	(no bleeding obser staff had not check when he arrived bastaff did not always R13's progress not at 1:39 p.m. include from R [right] arm a amount of bright blood on soiled dreapplied and when reduced and when reduced and when reduced and when reduced and when ressing and is no did not identify apploss, how long the pressure was applic communication to the R13's progress not a.m. included, "No prior to leaving for after dressing remound on 2/25/2021, at 8 R13's dialysis clinic 1/6/2021. R13's dialysis clinic 1/6/2021. R13's dialysis clinic 1/6/2021. R13's dialysis clinic 1/6/2021. R13's dialysis compressure held for a how long. Gauze woff this AM and pat some at this time. R13's dialysis compressived from 1/4/2	ved through shirt). R13 stated ed the bandage for bleeding lick at the facility, and stated check after the appointment. e dated 1/5/2021 (Tuesday), ed "When dressing removed area this morning small bood oozing from fistula. No essing. Another dressing now removed no ne [sic] on longer bleeding. R13 record roximate amount of blood site was bleeding, how long ed, and lacked evidence of the dialysis clinic. e dated 1/6/2021, at 10:45 bleeding form fistula R arm dialysis. No signs of bleeding	F 69			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245499	B. WING			C 02/26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP C 425 NORTH BADGER STREET CALEDONIA, MN 55921	;ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E	
F 698	During an interview licensed practical in the nurse working will bleeding and wrote stated that morning and thrill, there had the site was drippin applied a gauze probleeding, and wher only a small amount the bleeding had stathought she had reminutes. LPN-A stadialysis of the bleed large amount and the During an interview dialysis registered in R13's care manage notes dated 1/6/202 beginning of treatm had any post bleed of telling us and was knowledgeable wheread the visit note a stated the facility has site had post bleed depend on the amount considered an eme supposed to apply bleeding; stated the us of any bleeding it down it the command forth. R13's January and	on 2/25/2021, at 9:06 a.m. urse (LPN)-A stated she was when R13's dialysis site was the progress note. LPN-A she went in to check for bruit not been a bandage on, and g blood. LPN-A stated she essure dressing to stop the she came back there was at of blood on the dressing and opped. LPN-A stated she checked the site after 30 ted she had not notified ding because it was not a she bleeding stopped. If on 2/25/2021, at 8:29 a.m. nurse (DRN) stated she was er. DRN reviewed R13's visit 21, and stated at the eent patients are asked if they ing issues; R13 was capable as a reliable historian and en it came to his dialysis. DRN aloud from 1/6/2021, and ad not communicated R13's ing. DRN stated it would bunt of bleeding if it was regency. DRN stated staff were pressure if they noted e facility should have notified either via phone or by writing nunication book that goes back. February 2021 medication rd (MAR) identified the	F6	98		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245499	B. WING		_	02/2	26/2021
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		STREET ADDRESS, CITY, STAT 425 NORTH BADGER STREE CALEDONIA, MN 55921			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 698	physician orders for intake values range R13's January and administration recoorders to check the check marked boxe completed on every included the physic restriction, however with no fluid intake R13's record identification recorded in two are intake". The record with each other, and of evaluation/asses hour intake. Exampiliarly Exampiliarly Exampiliarly Fluid intake docum three boxes were boxes were boxes were boxes were left blair recorded; corresponding and evening and evening and in the morning and evening and even	r the Arginaid; recorded fluid and from 60 ml to 240 ml. February 2021 treatment red (TAR) identified physician fistula; the boxes had a se indicating the task was redialysis day. The TARs also ian order for 1500 ml fluid reall of the boxes had an "X", amount recorded. fied fluid intake was being as, "Meal intake" and "fluid ed values were not consistent determined the record lacked evidence sment of R13's twenty-four eles include the necessary in the lank; corresponding Meal indicated R13 consumed 240 and box was left blank, R13 or dinner. The MAR Arginaid consumed 120 ml in the eng. The nentation for 2/21/2021- two makes and 3rd box had 240 ml and makes for interest in the lang. The nentation for 2/21/2021- two makes and 3rd box had 240 ml and makes for intake for intake was arginaid consumption was 120 and evening. The nentation for 2/22/2021, two makes and two boxes had "0"; I intake for 2/22/2021, had to a blank box for lunch, and	F6	98			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245499	B. WING _			C / 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 698	boxes had "0" recocorresponding Meablank box for break 240 ml for dinner. To consumption was 2 ml in the evening. During an interview registered nurse (Forestered nurse) (Forestered n	nentation for 2/23/2021, two rded and one box was blank; al intake for 2/23/2021, had tfast, 240 ml for lunch, and	F 69	98		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245499	B. WING				26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		425	REET ADDRESS, CITY, STATE, ZIP CODE NORTH BADGER STREET LEDONIA, MN 55921	V Z.	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	buring an interview trained medication when she passed in the amount of fluid tracked fluid intake. During an interview RN-A stated if a respectation, the dietical fluid was divided over esident could have allowed for medicate were supposed to the resident was resoutside of what the "I don't believe that the 24 hour totals, of can't confirm that." During an interview director of nursing (did not identify dially when R13's dialysis should have been a dialysis communicate there should have been addialysis communicate there should have been addialysis communicate there should have been addialysis communicated and expected staff according to physical R13's fluid intakes a have a solid way fluid ocumented and expected staff according to physical R13's fluid intakes a have a solid way fluid ocumented and expected staff according to physical R13's fluid intakes a have a solid way fluid ocumented and expected staff according to physical R13's fluid intakes a have a solid way fluid ocumented and expected staff according to physical R13's fluid intakes and the physical R13's flui	ked that. on 2/26/2021, at 8:51 a.m. assistant (TMA)-A stated nedications she did not record intake and dietary staff on 2/26/2021, 9:18 a.m. sident was on a fluid cian determined how much were each meal, how much the in his room, and the amount tion passes. RN-A stated NA's communicate to the nurse if questing additional fluids y were provided. RN-A stated there is someone evaluating our dietician may go in but I on 2/25/2021, at 11:22 a.m. (DON) confirmed the record yes or provider was contacted as site was bleeding, and they and/or should have been in the ation book. DON indicated been documentation of was monitored for bleeding check the site after dialysis ian orders. DON reviewed and stated the facility did not uid intakes were being yaluation of the intakes was	F6	698			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245499	B. WING _			C / 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 698	and housekeeping if a resident is on flu a sheet of paper. C supposed to record the computer. CDM who was evaluating CDM stated an unadocumenting fluid immeals such as fluid during medication president requests. R23 R23's quarterly Min assessment, dated had moderately improper supervision with eartified a diagnost (ESRD), and receive R23's care plan, incomproblem related to renal disease and concluded a 1500 correstriction. R23's active physic restriction - 1200 coof 1/19/21. Review of R23's MR Record (MAR), and Record (TAR) printed 2/28/21, did not incompositioning by nursing the construction of the construction o	staff pass water twice per day, uid restriction it is identified on DM stated dietary staff are I fluid intake after each meal in I stated an unawareness of 24-hour daily fluid intakes. It was entake provided outside of s given during activities, passes, or extra amounts the paired cognition and required ting. The MDS further sis of end stage renal disease are dialysis services. Cluded a potential nutritional diet restriction for end stage diabetes. Interventions (cubic centimeter) fluid cian orders, included: Fluid cian orders, in	F 69	98		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET ALEDONIA, MN 55921	1 02/	-0/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	Fluid Restriction, 24 The undated form to the dietary manage 120 cc fluid restriction on 2/22/21, at 3:39 a 1200 cc fluid restriction of sure if staff were shared one night has overnight staff gaved didn't think I was sure if staff were shared one night has overnight staff gaved didn't think I was sure if staff were shared one night has overnight staff gaved didn't think I was sure if staff were shared one atting lunin an 8 ounce cup (straw. There were the meal. On 2/25/21, at 1:22 confirmed activity sat times for resident sirestriction; the resident on a fluid restriction resident was on a fluid restriction resident was on a fluid intake would monitor fluid intake would monitor fluid water pass. On 2/25/21, at 1:31 (NA)-H stated being	itled, Water Pass, provided by r (DM), indicated R1 was on a on with each water pass. p.m. R23 confirmed being on riction and stated, "But they enever I ask for it". R23 was e tracking her fluid intake and ad asked for water and the her a large mug, "I told staff I apposed to have all that." 4 p.m. R23 was observed in inch. The meal included juice 240 cc) with a cover and no other fluids included with p.m. activities aide (AA)-B taff could provide beverages ts. AA-B stated there was he knew of that was on a fluid dent was not R23. p.m., trained medication aide her knowledge, R23 was not a fluid restriction, nursing would with medications and dietary is consumed with meals and p.m. nursing assistant gunaware if R23 was on a lidn't work the east wing very	F6	698			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		425	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH BADGER STREET ALEDONIA, MN 55921	, V211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	On 2/25/21, at 1:35 (LPN)-A stated to h on a fluid restriction typically the dietary monitored what fluid on a fluid restriction fluids they administ LPN-A reviewed R2 confirmed R23 was restriction. When a document R23's flu "Good question". L and TAR and confir fluid intake by nursi On 2/25/21, at 1:43 (DM) confirmed die passing out water to documenting how residents on a fluid does the water pas who was on a fluid could receive. Diet much fluid was con it was around 240 cresident requested couldn't refuse the confirmed the dietic weekly, was respor for resident's on a feducate the resider prescribed. DM correstriction, and furth was recently reduced aily. DM was unstated	p.m. licensed practical nurse er knowledge, R23 was not at LPN-A further stated staff delegated and ds were received by residents and nursing would monitor ered on the MAR or TAR. 23's physician orders and on a 1200 cc daily fluid asked where nursing would id intake, LPN-A responded, PN-A reviewed R23's MAR med there was no tracking of	F 6	598			

AND DIAN OF CORRECTION INTERIOR NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	, 02	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 698	When interviewed of director of nursing (have been monitoridietary staff's monit further confirmed naware of R23's fluid When interviewed of DM confirmed dietathow much fluid was water pass. DM remeals and confirmed consistently docum consumed at each	DON 2/25/21, at 3:36 p.m. the (DON) confirmed staff shoulding R23's fluid intake and that oring was not complete. DON ursing should have been	F 6	98		
	10/2010, included: Mild bleeding from expected. Apply precontact dialysis cerl If there is major ble dialysis), apply prescontact emergency Verify that clamps a a medical emergen alone until emerger Pharmacy Srvcs/Procedures/FCFR(s): 483.45(a)(l) §483.45 Pharmacy The facility must predrugs and biological them under an agree §483.70(g). The facility from the facility must predrugs and biological them under an agree §483.70(g). The facility must predrugs and biological them under an agree §483.70(g).	eding from the site (post source to insertion site and services and dialysis center. are closed on lumens. This is cy. Do not leave resident acy services arrive. Pharmacist/Records b)(1)-(3)	F 7	55		4/14/21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		245499	B. WING _		C 02/26/2021
	PROVIDER OR SUPPLIER	I & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 755	permits, but only ur a licensed nurse. §483.45(a) Procedupharmaceutical ser that assure the acc dispensing, and adbiologicals) to meet §483.45(b) Service must employ or obtipharmacist whospharmacist w	ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. Consultation. The facility ain the services of a licensed des consultation on all ision of pharmacy services in olishes a system of records of ion of all controlled drugs in	F 75	1. Immediate action(s) taken fo resident(s) found to have been a include: (TMA)-A was reeducated on the requirement to have a Licensed I witness and sign for the controlle substance destruction of a Fenta and placed in a drug buster locat medication room on 2/26/21. 2. Identification of other resider	ffected Nurse ed nyl Patch ed in the

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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		245499	B. WING		02/2	26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 755	place on the skin e schedule. On 2/26/21, at 11:1 (TMA)-A was obsered the schecking the count book for the east we process for destroy fold the patch in habuster in the medical and nurse. The nurse the destruction on administration reconstruction on administration reconstruction and the last Fentanyl patched the from a licensed nurlicensed practical in the day shift on 2/2 evidenced the Fentanyl patched the fentanyl patch on a medication room the wealth of the fentanyl patch on a new patch. TMA-B half, then placed in unwitnessed. TMA Fentanyl patches we mediation room in a nurse. The directo present during the	age 91 y 72 hours for chronic pain very third day an remove per 5 a.m. trained medication aider ved reconciling R18's y counting the patches then against the narcotic ledgering. TMA-A confirmed the ring Fentanyl patches was to lf and dispose of in the drug ration room while evidenced by and TMA would then sign off the electronic medication rd (eMAR). It was noted that ratch administered to R18 on d in the eMAR as removed d as destroyed with evidence rese. TMA-A consulted with rurse (LPN)-A who had worked 5/21, and would have ranyl patch being destroyed. MA-B had administered east wing on 2/25/21, though rentanyl patch to the rat day to be destroyed. On 2/26/21, at 11:28 a.m. raving removed R18's 2/25/21, prior to applying a stated she folded the patch in a sharps container. B denied knowledge that were to be destroyed in the che drug buster with a licensed of nursing (DON) was interview and confirmed 2 staff off destruction of the Fentanyl	F 7	the potential to be affected was accomplished by: Current residents receiving Fenta Patches reviewed for the past thi for appropriate documented destr. No other residents found to be af 3. Actions taken/systems put into reduce the risk of future occurr include: Facilities TMA is and Licensed in be in serviced on the facility pract destroy controlled substances in presence of a Licensed Nurse and Licensed Nurse cosign the destroy manufacture's guidelines by April 2021. TMAs and Licensed nurse after April 14-2021 will be in serviced during orientation on this process 4. How the corrective action(s) monitored to ensure the practice recur: DON/Designee will complete ranguidits of the EMAR 2 x week for month then 1 x wk for two months validation the medication destructoring cosigned. Results of finding will be reviewed QAPI monthly and compliance variafter 3 months. Corrective action completion04/14/2021	ty days uction. ected. o place ence urse will ice to he d for the ction. d per 14- hired ced . vill be will not dom one s for ion is I in lidated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499		B. WING		C 02/26/2021	
	NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 755	sharps container w	as unaware disposal in a vas no longer acceptable. yl patch destruction was	F 7	755			
F 758 SS=D	Free from Unnec F CFR(s): 483.45(c) §483.45(e) Psycho §483.45(c)(3) A ps that affects brain a processes and bel	Psychotropic Meds/PRN Use (3)(e)(1)-(5) otropic Drugs. ychotropic drug is any drug ctivities associated with mental navior. These drugs include, to, drugs in the following	F 7	58		4/14/21	
	system (1) Responder (2) Respo	ehensive assessment of a y must ensure that idents who have not used are not given these drugs tion is necessary to treat a as diagnosed and documented rd; idents who use psychotropic lual dose reductions, and ntions, unless clinically an effort to discontinue these idents do not receive a pursuant to a PRN order attion is necessary to treat a accondition that is documented					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED	COMPLETED		
		245499	B. WING		C 02/26/2021	
	NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	02/20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE COMPLÉTIO	N
F 758	are limited to 14 da §483.45(e)(5), if the prescribing practition appropriate for the beyond 14 days, he rationale in the resident in the resident in the resident in the resident in the duration should be appropriate to the appropriatenes. This REQUIREMED by: Based on interview facility failed to compassessment to deteordered for insomman reviewed for unnecessive disordered for insomman reviewed for unnecessive disordered bata Set (MDS) as indicated R12 did nor difficulty sleeping energy. R12's physician or MG (milligrams) Girman reviews Girling and		F 758	1. Immediate action(s) taken for tresident(s) found to have been affeinclude: R 138 had a sleep log initiated upoadmission 2/25/21 – 3/17/21 2. Identification of other residents the potential to be affected was accomplished by: Current resident with sleep medicareviewed for a current sleep log. Notesidents found not to have a sleep completed in the past quarter. 3. Actions taken/systems put into to reduce the risk of future occurre include: Licensed Nurses will be in serviced facility practice to have a sleep log completed on new/re admissions, quarterly, annually and with significe change for long term residents presidents presidents presidents presidents presidents presidents and service of the servi	ected on s having ation o other o study place nce d on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	COM	E SURVEY PLETED		
		245499	B. WING			02/26/2021		
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 759 SS=D	for this order was 1 R12's care plan did non-pharmacologic R12's medical reco comprehensive sle of sleep monitoring Trazodone. R12s physician visi 2/1/2021 included,' 92-year-old womandenies depressio" During an interview director of nursing to locate sleep mor for R12. The DON was completed to r continued use of th During an interview registered nurse (R assessments would assessments and if would assume a sle done. RN-A stated completed quarterly condition and chan A policy and proced was requested and Free of Medication	O/29/2018. Inot include ral interventions for sleep. Ind lacked evidence of a represent and analysis for continued use of It progress note dated the patient is a pleasant and analysis for continued use of the patient is a pleasant and an appetite or sleep problems In on 2/25/21, at 9:03 a.m. the (DON) stated she was unable altoring or a sleep assessment verified a sleep assessment verified a sleep assessment relip determine justification for the medication. In on 2/02/25/21, at 5:17 p.m. and the patient of the documented under the was unable to find one there, represent the passessment had not been sleep assessments should be an annually, with a change of ge of sleep. It was unable to find one there, represents should be annually, with a change of ge of sleep. It was unable to find one there, represents should be annually, with a change of ge of sleep. It was unable to find one there, represents should be annually, with a change of ge of sleep. It was unable to find one there, represents should be annually, with a change of ge of sleep.	F 75	a sleep medication by April Licensed Nurses hired after will be in serviced during or this process. DON/Designee will validate admissions receiving sleep have a sleep log initiated dumorning clinical meeting. DON/Designee will validate quarterly, annual, and signit care assessment that of resreceiving scheduled sleep rinsomnia have had a sleep notified of results. 4. How the corrective action monitored to ensure the prarecur: DON/Designee newly order medication 2 x week for one x wk for two months for appinitiation and completion of physician notification of log Results of finding will be rev QAPI monthly and compliar after 3 months.	April 14-2021 ientation on new / re medication uring the next during ficant change sidents that are medication for log and MD on(s) will be actice will not red sleep e month then 1 ropriate sleep log and results viewed in	4/14/21		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		(X3) DATE SURVEY COMPLETED	
	245499	B. WING		02/26/2021	
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER			125 NORTH BADGER STREET	<u> </u>	· · · · · · · · · · · · · · · · · · ·
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
The facility must en §483.45(f)(1) Media percent or greater; This REQUIREMEN by: Based on observar review, the facility of a medication errogreater. The facility of 7.69% percent wopportunities for en (R11) who were obpass. Findings include: R11's Admission RR11 had diagnoses convulsions and an R11's Order Summ orders), included on Tegretol (carbamaz medication used to milligrams (mg) giv times a day, fish oil mouth two times a anticonvulsant medication used to milligrams (mg) giv times a day, ms by mouth in the moone tablet by mouth paroxetine HCI (an 20 mg give 40 mg kg	cation error rates are not 5 NT is not met as evidenced cion, interview and document ailed to ensure they were free or rate of five percent or y had a medication error rate with 2 errors out of 26 cor involving 1 of 7 residents served during the medication eccord (face sheet), indicated including unspecified xiety disorder. ary Report (physician's ders for epine) (an anticonvulsant treat seizure disorders) 200 e 1 tablet by mouth three 1000 mg give one capsule by day, gabapentin (an lication also used to treat give 2 capsules by mouth agnesium oxide give 400 mg rning, multiple vitamin give in the morning, and antidepressant medication) by mouth in the morning.	F 759	1. Immediate action(s) taken for t resident(s) found to have been affer include: R 11 did not receive any medication prescribed. (TMA)B was reeducated on the right medication delivery and had a medication of other residents the potential to be affected was accomplished by: Current residents receiving medical a TMA potential could have been a successful as a country and had been as a country as a country and had been as	n not hts of dication 26/21. A role having tion by ffected. place nce on the ave a eleted April	
•					
	PROVIDER OR SUPPLIER NIA REHABILITATION SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa The facility must en §483.45(f)(1) Medic percent or greater; This REQUIREMEN by: Based on observat review, the facility fo f a medication erro greater. The facility of 7.69% percent w opportunities for en (R11) who were observat pass. Findings include: R11's Admission Re R11 had diagnoses convulsions and an R11's Order Summ orders), included or Tegretol (carbamaz medication used to milligrams (mg) give times a day, fish oil mouth two times a day anticonvulsant med nerve pain) 100 mg two times a day, ma by mouth in the mo one tablet by mouth paroxetine HCI (an 20 mg give 40 mg to On 2/24/21, at 8:03	PROVIDER OR SUPPLIER NIA REHABILITATION & RETIREMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 95 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 7.69% percent with 2 errors out of 26 opportunities for error involving 1 of 7 residents (R11) who were observed during the medication pass.	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 95 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 7.69% percent with 2 errors out of 26 opportunities for error involving 1 of 7 residents (R11) who were observed during the medication pass. Findings include: R11's Admission Record (face sheet), indicated R11 had diagnoses including unspecified convulsions and anxiety disorder. R11's Order Summary Report (physician's orders), included orders for Tegretol (carbamazepine) (an anticonvulsant medication used to treat seizure disorders) 200 milligrams (mg) give 1 tablet by mouth three times a day, fish oil 1000 mg give one capsule by mouth two times a day, magnesium oxide give 400 mg by mouth in the morning, multiple vitamin give one tablet by mouth in the morning, and paroxetine HCI (an antidepressant medication aide On 2/24/21, at 8:03 a.m. trained medication aide	A BUILDING	A BUILDING 245499 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH ODERCITY STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODERCITY STATE, ZIP CODE 426 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODERCITY STATE, ZIP CODE 427 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODERCITY STATE, ZIP CODE 428 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODERCITY STATE, ZIP CODE 427 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODERCITY STATE, ZIP CODE 428 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODERCITY STATE, ZIP CODE 427 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODERCITY STATE, ZIP CODE 428 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODERCITY STATE, ZIP CODE 427 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODERCITY STATE, ZIP CODE 428 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODERCITY STATE, ZIP CODE 427 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDERS PLAN OF CORRECTION (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDERS PLAN OF CORRECTION (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE 1. Immediate action (s) taken for the resident(s) found to have been affected include: R 11 did not receive any medication not prescribed. ([TMA]B was removed from the TMA role 2. Identification of other residents having the potential to be affected was accomplished by: Current residents received on the rights of medication about the residents received any medication by a TMA potential coult have been affected. 3. Actions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NI IMPED: ` ´		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	245499 B. WING			C 02/26/2021			
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER				STREET ADDRESS, CITY, STATE, ZIP 425 NORTH BADGER STREET CALEDONIA, MN 55921	•		
(X4) ID PREFIX TAG			EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 759	R11 in the followir tablets, Tegretol 2 magnesium oxide tablet. After dishin TMA-A obtained a package (a packir pre-formed plastic folds together to fone of the tablets handed the packar The medication we tablet by mouth the sticker on it that rebrought to TMA-B already dished up and that this was removed the Tegroup, then obtained blister package are of the blister package are of the blister pack then handed the preview. The medi mouth three times pointed out to TMA dished up that me removed the extracup. TMA-B state Tegretol 20 mg but Surveyor asked Tegretol 20 mg but Surveyor advised medication than Tegretol 20 mg Sur	age 96 ag order: gabapentin 100 mg-2 00 mg, fish oil 1000 mg, 400 mg, and multiple vitamin-1 ng up the multiple vitamin, medication in a blister ag design consisting of attached to a backing or that orm a seal). TMA-B pushed out of the blister package, then ge to the surveyor to review. as Tegretol 200 mg give one ree times a day and had a blue ead, "Bedtime". Surveyor as attention that she had R11's morning Tegretol dose the bedtime dose. TMA-B etol tablet from the medication of another different medication of pushed one of the tablets out age into the medication cup, eackage to the surveyor to cation was Tegretol 200 mg by or a day. Again, surveyor A-B that she had already dication. TMA-B then again or dose of Tegretol from the med of it was supposed to be of toculdn't find a 20 mg tablet. MA-A to show the surveyor the or the computer for the as trying to find. TMA-B der; the medication was by mouth in the morning. TMA-B that it was a different eaction; TMA-B then found the or in the med cart and placed	F 7	are being followed. Results of finding will be re QAPI monthly and complia after 3 months.			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION DING	COV	(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C / 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 759	Continued From pa	ge 97	F 7	759		
F 761 SS=D	revised 11/28/20, in administering the malabel to verify the right.	and Biologicals	F 7	761		4/14/21
00 B	§483.45(g) Labeling Drugs and biologica labeled in accordan professional princip appropriate access	g of Drugs and Biologicals als used in the facility must be ace with currently accepted bles, and include the				
	§483.45(h) Storage	of Drugs and Biologicals				
	Federal laws, the fabiologicals in locked	cordance with State and acility must store all drugs and d compartments under proper ls, and permit only authorized access to the keys.				
	separately locked, p compartments for s listed in Schedule II Abuse Prevention a other drugs subject facility uses single a systems in which the and a missing dose This REQUIREMEN by:	facility must provide permanently affixed storage of controlled drugs. I of the Comprehensive Drug and Control Act of 1976 and to abuse, except when the unit package drug distribution he quantity stored is minimal e can be readily detected. NT is not met as evidenced tion, interview and document		Immediate action(s) taker	n for the	
		ailed to ensure 2 of 2		resident(s) found to have been		

PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY PLETED
		045400				С	
		245499	B. WING			02/2	26/2021
	REHABILITATION	& RETIREMENT CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
treat loci Fin On sou no aid corr sho corr ket nys res On east top pre TM her me froi loci car who sto treat beet the pro TM did and	indings included: in 2/24/21, at 8:30 auth treatment can staff present. At le (TMA)-C approfirmed the top douldn't have been tained 24 lotions to conazole presonation powder, prosidents. in 2/24/21, at 8:32 statin powders to a stati	a.m. the top drawer of the t was observed unlocked with 8:31 a.m. trained medication bached the treatment cart and rawer was unlocked and n. The top drawer of the cart is and ointments, 2 cription shampoo and 2 escribed for 10 different a.m. the top drawer of the was observed unlocked. The was observed unlocked. The art contained several is ointments and powders. In a setting up 137 a.m. TMA-B walked away liminister medication. TMA-B on cart but not the treatment TMA-B returned to the area on and treatment carts were firmed the top drawer of the unlocked and shouldn't have inpted to lock the top drawer; itsm wasn't functioning unable to secure the cart. Would let maintence know but rescribed lotions, ointments	F 7	7 61	include: (TMA)-B was reeducated on the requirement to keep the medication treatment cart locked when not in ron 2/24/21. (TMA)-C was reeducated on the requirement to keep the medication treatment cart locked when not in ron 2/24/21. 2. Identification of other residents the potential to be affected was accomplished by: Current residents receiving medica a TMA potential could have been a 3. Actions taken/systems put into to reduce the risk of future occurrer include: TMA's will be in serviced on the requirement to keep the medication treatment carts completed by April 14-2021. TMAs hired after April 14-will be in serviced during orientation this process. Pharmacy to have new treatment or replaced by April 14-2021. 4. How the corrective action(s) with monitored to ensure the practice with recur: DON/Designee will complete randous observations of the treatment and medication carts audits 2 x week for month then 1 x wk for two months availation they are appropriate sec Results of finding will be reviewed QAPI monthly and compliance validation after 3 months.	each n and each having tion by ffected. place nce n and -2021 n on earts fill be ill not om or one for ured. in	

Event ID: TVJH11

PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245499		B. WING		C 02/26/2021	
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	•	26/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880 SS=F	locked and secured On 2/26/2, at 11:15 was observed unlominutes later TMA-cart was unlocked at The policy titled, Acrevised 11/28/20, in administration of more cart is kept closed at of the medication in Infection Prevention CFR(s): 483.80(a)(Secure 1)(Secure 1)(Sec	a.m. the east medication cart cked. Approximately two A arrived and confirmed the and shouldn't have been. Idministering Medications, adicated: 9. During edications, the medication and locked when out of sight urse or aide. The A Control (1)(2)(4)(e)(f) Control stablish and maintain an and control program as asfe, sanitary and ament and to help prevent the transmission of communicable tions. In prevention and control stablish an infection prevention on (IPCP) that must include, at	F 7			4/14/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245499	B. WING	B. WING		C 02/26/2021	
	NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER				EET ADDRESS, CITY, STATE, ZIP CODE NORTH BADGER STREET LEDONIA, MN 55921	, , ,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	standards; §483.80(a)(2) Writte procedures for the put are not limited to (i) A system of surve possible communical infections before the persons in the facility. When and to whose communicable disereported; (iii) Standard and treprecautions to be for infections; (iv) When and how it resident; including the facility. When and how it resident involved, and (B) A requirement the circumstances. (v) The circumstances. (v) The circumstances. (v) The circumstances. (vi) The circumstances. (vi) The hand hygier by staff involved in §483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must half	en standards, policies, and program, which must include, oceillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based ollowed to prevent spread of solation should be used for a put not limited to: aration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ses under which the facility eyees with a communicable skin lesions from direct the disease; and the procedures to be followed direct resident contact.	F8	880			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/26/2021	
		245499	B. WING			
	NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
F 880	IPCP and update the This REQUIREMENT by: Based on observareview, the facility of Disease Control (Coand/or minimize the by ensuring staff ut protective equipment including the use of care to residents of the facility during the facility during the standard facility during the standard facility admission presument quarantined in their residents (R139) were sident council meaton ensure proper in administering media (R11) observed during the facility on 2/12/2 included obstructive hernia with gangres R138's hospital dis during R138's hospital dis during R138's hospital dispression. The surface of the facility on the facility on 2/12/2 included obstructive hernia with gangres.	review. duct an annual review of its neir program, as necessary. NT is not met as evidenced tion, interview and document ailed to follow the Centers for DC) guidelines to prevent e transmission of COVID-19 ilized appropriate personal nt (PPE) precautions, f gowns, when providing direct ewly admitted/re-admitted to neir 14-day quarantine for 3 of R139, R137) observed. in failed to ensure new ed positive residents were r room for 14-days for 1 of 1 ho attended the group seting. The facility also failed fection control technique while cation for 1 of 7 residents ring medication administration. identified an admission date 021, with diagnoses that e sleep apnea and ventral	F 880	1. Immediate action(s) taken for tresident(s) found to have been afferinclude: R 138 was discharged on 3/16/202 R 139 is no longer on new admissi quarantine. R 137 is no longer on new admissi quarantine. (TMA)-B was reeducated, and a medication pass observation compon 3/26/21. RN-A was reeducated on appropriate PPE for residents on isolation on 2 (NA)-E was reeducated on appropriate PPE for residents on isolation on 2. 2. Identification of other residents the potential to be affected was accomplished by: Current review of residents that ha admitted/Readmitted within the past day had appropriate signage for Intercept precaution outside their room door required PPE outside their rooms available for staff. Medication Pass observation for propriate in the propriate of the propriate in the propriate of the propriate	ected 21. on on on eleted ate /26/21. riate /26/21. s having d been st 14 fection and roper with	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245499	B. WING		C 02/26/2021	
	NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	, , , , , , , , , , , , , , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
F 880	have expiratory wh X-ray showed persopacities with some lobe, possible pneudobe, possible	eezes to auscultation.", chest istent bilateral airspace progression in the left lower amonia. ion on 2/22/2021, at 3:07 p.m. of have signage or personal nt (PPE) outside of his room R138's required transmission R138 was observed to be	F 880	3. Actions taken/systems put into to reduce the risk of future occurred include: Facility s staff will be in serviced by 14-2021 on appropriate PPE usage Isolation Precautions. Facility staff after April 14-2021 will be in serviced during Orientation on appropriate Fusage by Isolation precautions. Facilities Licensed nurse will be in serviced by April 14-2021 on approxisolation signage and PPE available outside of resident is room for new admissions. Licensed Nurses hired April 14-2021 will be in serviced du Orientation on appropriate isolation signage and PPE availability outside resident is room for new admission Facilities TMA is will have a medic pass Infection control reeducation and observation completed by April 14-TMAs hired after April 14-2021 will medication pass Infection control education and an observation comiduring Orientation. DON/Designee will validate new /readmission residents isolation precaution signage and PPE outside the room is present prior to resident arrival to the facility. DON/Designee will complete Medic pass observations for TMAs on a minimum of a biannual basis. 4. How the corrective action(s) with monitored to ensure the practice werecur:	April e by hired ed PPE priate lity I after ring le of ns. ation and an 2021. have pleted de of it s cation	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245499	B. WING		C 02/26/2021	
	NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921		20/2021
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	disease. R139's hospital dis 2/19/2021, indicate Covid-19 on 2/19/2 include why R139 v. During an observat 2/22/2021, at 3:30 signage or PPE outhis bed. R139 state to the facility a couphad informed him hquarantined for a wout of his room to gobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced by the sield however did changed R139's grobserved to have reduced however did changed R139's grobserved however did chang	charge summary dated d R139's tested negative for 021. The summary did not was tested for COVID-19. ion and interview on p.m. R139's room did not have tside of his room. R139 sat in ed he had just been admitted ole of days ago; facility staff he was supposed to be while and had been only been net weighed. R139 was not respiratory symptoms. ion on 2/23/2021, at 8:52 a.m. of nursing (DON) were in wore a face mask and face not have a gown on. RN-A oin dressing. R139 was not respiratory symptoms. identified an admission date with diagnoses including and avoidant personality ion and interview on p.m. R137's room did not have tside of her room. R137 stated tted to the facility almost two was not observed to have	F 880	DON/Designee will audit new ad 2x/week for one month then 1 x v two months for appropriate isolat precaution signage and PPE out the room. DON/Designee will corone TMA random Medication pass observation 2x/week for one mor x wk for two months for appropria infection control practices. Results of finding will be reviewed QAPI monthly and compliance varieties 3 months.	wk for tion side of mplete ss ofth then 1 ate	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C / 26/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 425 NORTH BADGER STREET CALEDONIA, MN 55921	.		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	NA-H indicated that the facility put reside hospital and those (R137, R138, and Inot ever been requision hospital admissions shields. NA-H confisignage or PPE state front of the resident an employee of the the nurse to find our precautions. NA-H not had any sympto admitted with a dry go; stated it was so COVID-19. During an interview licensed practical in there was not PPE the resident's room related to hospital at there was a cause should be worn. When interviewed director of nursing that are admitted or into the facility need are quarantined to stated at the last fautilizing full PPE which resident on quarant facility staff had not entering quarantined.	on 2/23/2021, at 4:06 p.m. It the one hallway was where lents who came from the residents were on quarantine, R139). NA-H stated we have ired to wear gowns for so, only masks and face irmed that there was no ations down that hallway or in the rooms, and if you were not efacility you would have to ask at if there were any special stated R137 and R139 have oms, and R138 had been cough that would come and omething else besides of on 2/23/2021, at 4:11 p.m. attractions or signage in front of so that were on quarantine admissions. LPN- indicated if of concern, then gowns on 2/23/21, at 3:15 p.m. the (DON) confirmed all residents or re-admitted from the hospital dangative Covid-19 test and their room for 14 days. DON cility she worked at the staffmen entering the room of a tine and confirmed at this the been utilizing gowns when end resident rooms. DON was gowns were on hand at the	F 8	80			

AND DI AN OF CORRECTION I DENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		42	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET EALEDONIA, MN 55921	1 02/	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	facility. When interviewed of confirmed the facility storage and would precautions includir immediately for the residents. The policy titled CO indicated: Persons suspected covid in precautionary measure be handled as follow precautions, contact protection, and a magnitude protection, and a magnitude protection on the door. R11 medication admits Admission Re R11 had diagnoses convulsions and an R11's Order Summorders) signed 2/25 Tegretol (carbamaz medication used to milligrams (mg) give times a day, fish oil mouth two times a day, fish oil mouth two times a day, magnitude pain) 100 mg two times a day, magnitude pain) 100 mg two times a day, magnitude pain houth the moone tablet by mouth paroxetine HCI (an	on 2/23/21, at 4:36 p.m. DON by had 8 cases of gowns in be initiating dropleting the use of gowns new and re-admitted OVID-19, revised 6/1/20, Under Investigation (PUI)/ the facility. As a sure, any suspected cases will ws: Use standard of precautions, and eye askPrecaution signs will be ministration ecord (face sheet), indicated including unspecified	F8	880			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	& RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIF 425 NORTH BADGER STREET CALEDONIA, MN 55921	P CODE	02/	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 880	(TMA)-B was obser R11 in the following tablets, Tegretol 20 magnesium oxide 4 tablet. After dishing TMA-A obtained a rpackage (a packing pre-formed plastic a folds together to for one of the tablets o handed the packag The medication was tablet by mouth thresticker on it that reabrought to TMA-B's already dished up Fand that this was thremoved the Tegret cup with her bare hedication back into the obtained a difficulty package and pushed blister package into handed the packag The medication was three times a day. TMA-B that she had medication. TMA-E dose of Tegretol frohands, then replace the blister package. When interviewed of TMA-B confirmed it tape medications be	a.m. trained medication aide ved setting up medications for order: gabapentin 100 mg-2 mg, fish oil 1000 mg, 20 mg, fish oil 1000 mg, 200 mg, and multiple vitamin, medication in a blister design consisting of attached to a backing or that im a seal). TMA-B pushed ut of the blister package, then to the surveyor to review. Tegretol 200 mg give one see times a day and had a blue ad, "Bedtime". Surveyor attention that she had R11's morning Tegretol dose to bedtime dose. TMA-B col tablet from the medication ands, then replaced the to the blister package. TMA-A erent medication blister ad one of the tablets out of the othe medication cup, then the to the surveyor to review. Tegretol 200 mg by mouth Again, surveyor pointed out to dialready dished up that again removed the extra medication back into	F 8	80			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DPLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3	(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C 02/26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZI 425 NORTH BADGER STREET CALEDONIA, MN 55921	P CODE	V2/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIAT	(X5) COMPLETION DATE
F 880	confirmed it was ok remove the medica utilized the hand sa When interviewed of director of nursing (expect the TMA or administration to dispopped out of a blist place it back into the back. DON furt be touching medicathis was an infection. The policy titled, Activised 11/28/20, in established facility is (e.g., handwashing isolation precaution the administration of RESIDENT COUNCE R139's face sheet, to facility of 2/20/21 diabetes and chron disease. R139 attended the meeting held during 10:00 a.m. R139 with facility and should held the meeting held during 10:00 a.m. R139 with facility and should held for the meeting held during 10:00 a.m. R139 with facility and should held for the meeting held during 10:00 a.m. R139 with facility and should held facility and s	to use her bare hands to tions from the med cup as she initizer so much that it's ok. on 2/24/21, at 1:20 p.m. the (DON) stated she would nurse doing medication scard a medication if it was ster package in error, and not e blister package with tape on ther confirmed staff should not ations with their bare hands as an control concern. Idministering Medications, adicated: Staff shall follow infection control procedures, antiseptic technique, gloves, as, etc.) when these apply to of medications. CIL MEETING identified an admission date with diagnoses including ic obstructive pulmonary facility resident council of the survey on 2/23/21, at as a new admission to the nave been on 14 day	F 8	80		

PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING			C 26/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921	02/	20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 883 SS=D	positive and was or every new admission presumed positive the 400 hall was the DON stated the act R139 was on a quadefense we did not indicate the resider quarantine. The Doresidents were to such a stated there was between her and at The AD stated there was between her and at The AD stated she participate in the residence he was or was fine as she that completed in individual influenza and Pneu CFR(s): 483.80(d) (1) Influenza immunizations §483.80(d) (1) Influenza immunizations §483.80(d) (1) Influenza immunizations §483.80(d) (1) Influenza immunization octobro potential side effect (ii) Each resident is immunization Octobro annually, unless the contraindicated or timmunized during th	dmission and was presumed in quarantine. The DON stated on to the facility was on 14-day quarantine and stated in facility quarantine and stated in facility director (AD) was aware arantine hall and stated in her have anything posted to into on the 400 hall were in ON stated presumed positive tay in their rooms for 14 days. If on 2/25/21, at 11:39 a.m. the is a misunderstanding dmission coordinator (AC), asked the AC if R139 could insident council meeting in quarantine and AC stated it ought interviews would be dual rooms. Improved a minimumizations (AC) in the influenza immunization, in the influenza immunization, in the influenza immunization, in the influenza immunization, in the influenza immunization; in offered an influenza immunization; in offered an influenza immunization; in the immunization is medically the resident has already been in the influent in the immunization is medically the resident has already been in the influent in the immunization is medically the resident has already been in the influent in the immunization is medically the resident has already been in the influent in the immunization is medically the resident has already been in the immunication in the immunication is medically the resident has already been in the influent in the influence in the immunication is medically the resident has already been in the influence in the influen	F 8			4/14/21	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245400				С	
		245499	B. WING		02/	26/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 883	(iv)The resident's in documentation that following: (A) That the resider was provided educand potential side eimmunization; and (B) That the resider immunization or dicimmunization due to refusal. §483.80(d)(2) Pneumust develop policitation. §483.80(d)(2) Pneumust develop policitation. (ii) Before offering the immunization, each representative receive benefits and potentimmunization; (iii) Each resident is immunization, unleaded and potential immunization. (iii) The resident or has the opportunity (iv)The resident's indocumentation that following: (A) That the resider was provided educand potential side eimmunization; and (B) That the resider pneumococcal immunication or incomplete	nedical record includes indicates, at a minimum, the action regarding the benefits effects of influenza the either received the influenza to medical contraindications or amococcal disease. The facility the endication regarding the resident or the resident's eives education regarding the eital side effects of the effects of the endicated or the resident has nized; the resident's representative to refuse immunization; and medical record includes eindicates, at a minimum, the ent or resident's representative enteresident's representative enter	F 8	883			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY PLETED
		245499	B. WING			02/2	26/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
041.500	ANIA DELLABILITATION	LA DETIDEMENT OFNITED		42	25 NORTH BADGER STREET		
CALEDO	INIA REHABILITATION	& RETIREMENT CENTER		С	ALEDONIA, MN 55921		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 883	by: Based on interview facility failed to provo vaccinations were used. (R18, R23, R31) and vaccinations were used. (R18, R31) reviewed. R18's Admission Massessment dated admission date of 1 indicate whether R1 indicate whether R2 influenza and pneusit indicate if the resideclined the vaccin R18's medical recostifluenza or pneum offered or received. R23's quarterly MD admission date of SR23 was not currend but did not indicate vaccination had been further review of R1 include evidence and been offered. R31's quarterly MD admission date of 1 indicate whether R3 influenza vaccination resident had been ovaccination. The M not up to date on here	and document review the vide evidence influenza up to date for 3 of 5 residents and pneumococcal up to date for 2 of 5 residents and for vaccinations. Inimum Data Set (MDS) 1/13/21, indicated an 1/5/21. The MDS did not 18 was current on her mococcal vaccinations nor did dent had been offered and ations. Further review of red did not include evidence an ococcal vaccination had been offered and ococcal vaccination had been	F 8	883	1. Immediate action(s) taken for the resident(s) found to have been affer include: R18 Influenza consent completed of 3/26/21. Resident declined vaccine Pneumococcal consent completed of 3/26/21. Resident declined vaccine R23 Influenza consent completed of 3/26/21. Resident declined vaccine Pneumococcal consent completed of 3/26/21. Resident declined vaccine R31 Influenza consent completed of 10/15/20. POA accepted vaccine. N3/26/21. Pneumococcal consent completed on 10/15/20. POA accepted vaccine. Vaccine administered on 3/26/21. 2. Identification of other residents the potential to be affected was accomplished by: Current residents records audit for Influenza and Pneumococcal consent other resident found without consent Current residents MDS reviewed, 1 residents found without MDS immunization documentation. 3. Actions taken/systems put into to reduce the risk of future occurrent include: The Director of Nursing (DON) /Dewill monitor for completion of Influe consent completion and submission the MDS until April 1,2020. MDS Coordinator/Unit Manger will educated on completing the vaccin	both ents.12 nt. 2 place nce signee nza n on be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245499	B. WING				C 26/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET CALEDONIA, MN 55921	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 883	vaccination had been Further review of R include evidence are vaccination had been was was interviewed, confirmed finding numedical record that vaccinations had been on evidence in R23 influenza vaccinations received.	en offered and declined. 18's medical record did not influenza or pneumococcal en offered or received. the director of nursing (DON) of evidence in R18 and R31's influenza or pneumococcal een offered or received, and its medical record that an on had been offered or	F8	883	sections of the MDS by April 14,20 The new MDS coordinator will be in serviced during orientation on the requirement of completing the Vacasection of the MDS. Licensed nursing staff will be in set on completing the Pneumococcal during the admission process by A 14-2021. Licensed nurses hired aff 14-2021 will be in serviced during orientation on this process. Facility nurses will be in serviced in September of 2021 on the requirer complete the Influenza consent for current residents and residents with admission process. DON/Designee will review resident chart in morning clinical meeting for completed Pneumococcal Consent DON/Designee will review the MDS immunization section prior to the M submission. 4. How the corrective action(s) with monitored to ensure the practice with recurring the completed Pneumococcal consents. DON/Designee will audit new admit charts 2x/week for one month then for two months for completed Pneumococcal consents. DON/Designee will audit new admit charts 2x/week for one month then for two months for completed Pneumococcal consents. DON/Designee will audit new admit charts 2x/week for one month then 1 x wk for two months for completed Immunization section Results of finding will be reviewed QAPI monthly and compliance validation after 3 months.	cines rvice consent pril cer April n nent to h the ts' r ts. SIDS III be iIII not ssion 1 x wk signee week months n. in	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 19, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: TVJH11

Dear Administrator:

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

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> 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.

Caledonia Rehabilitation & Retirement Center March 19, 2021 Page 2

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

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

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

Office: (507) 206-2727 Mobile: (507) 461-9125

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mistain

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00073	B. WING		02/2) 6/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING CORRECTION ORDER					
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of the Minnesota Departments of the corrected requires or requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will sment of a fine even if the item				
	You may request a that may result from orders provided that the Department with notice of assessment in the Department of assessment in the Department with notice of assessment in the Department with notice of assessment in the Department of assessment o	n 2/26/2021 a survey was mine compliance for State owing correction orders are cate in your electronic plan of have reviewed these orders,				

 $\dot{\text{LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE}$

Electronically Signed 03/27/21

TITLE

STATE FORM 6899 TVJH11 If continuation sheet 1 of 58 Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00073	B. WING		02/2	26/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ige 1	2 000			
		int investigations were also me of the licensing survey.				
	The following comp UNSUBSTANTIATI H5499044C (MN63					
	SUBSTANTIATED H5499041C (MN62 at 0685 and 1325	plaints were found to be with deficiencies: 2263), licensing oders issued 6088), citation issued at 0830				
2 475	MN Rule 4658.026 Accounting and Re	0 Subp. 3 Personal Fund cords	2 475			4/14/21
	must establish and ensures a full and of accounting, accord accounting princip	ng system. A nursing home if maintain a system that complete and separate ing to generally accepted les, of each resident's rusted to the nursing home on lf.				
	by: Based on interview facility failed to pro- resident fund accou R12, R28, R138) re facility failed to mai	ent is not met as evidenced and document review, the vide quarterly statements for unts for 4 of 4 residents (R10, eviewed. In addition, the ntain a separate accounting of ds and failed to follow		Corrected.		

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00073		B. WING			C 26/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE		20/2021
	NIA REHABILITATION	I & DETIDEMENT		TH BADGER	,		
CALEDO	INIA KEHABILITATION	A & RETIREWIENT	CALEDO	NIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 475	Continued From pa	ge 2		2 475			
		es for the accounts. I lents who had reside by the facility.					
	Findings include:						
		on 2/22/21, at 6:51 received a quarterly facility.					
	the business office had a personal trus indicated R10 was stated the personal sent out on a quarte stated the previous was the 1/16/21 and unable to determine	on 02/25/21, at 11:2 manager (BOM) start account with the far admitted 7/2/2020. The funds statements werly statement. The EBOM's last day at the dindicated she had be the last time the prequarterly statements.	ted R10 cility and The BOM ere to be BOM ne facility been evious				
	the administrator are last week quarterly sent to residents. The stated the previous were behind on sere and stated they had records of when last sent out to resident resident had trust a unable to determine money was in each stated she was plare the deposit slips to was in each account documentation of diresident funds were	on 02/25/21, at 12:2 and BOM stated they statements were not he administrator and person had indicate ading out quarterly statements. The BOM stated 1 accounts and the facile at this time how must resident account. The account of the base of the	identified It being It BOM It they It any Its were Its current Ity was Ithe BOM Ink to get Ithe money Itated the Itated t				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY
,	0. 00	.5	A. BUILDING:			
		00073	B. WING		02/2	26/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 475	Continued From pa	age 3	2 475			
	money transferred	g to work with her to get into an interest- bearing I she talked to the bank about				
	A policy on personal requested and not	al funds accounts was provided.				
	The business office could review any performance and make Appropriate staff country changes. The I develop a system to compliance and representations.	rHOD OF CORRECTION: e manager (BOM) or designee olicies, procedures or facility lent funds including account any necessary revisions. ould be educated regarding BOM or designee could o monitor for on-going port results to the quality nittee for ongoing monitoring.				
	TIME PERIOD FOR Days	R CORRECTION: Twenty-one				
2 480	MN Rule 4658.026 Accounting and Re	0 Subp. 4 Personal Fund cords	2 480			4/14/21
	financial record mu quarterly statement resident or the resident conservator, repres	record. The resident's ust be available through ts and on request to the dent's legal guardian, sentative payee, or other in writing by the resident.				
	by: Based on interview facility failed to pro- resident fund account R12, R28, R138) re	ent is not met as evidenced and document review, the vide quarterly statements for unts for 4 of 4 residents (R10, eviewed. In addition, the intain a separate accounting of		Corrected.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED		
		00073		B. WING			C 26/2021
NAME OF	PROVIDER OR SUPPLIER	00070	STDEET AD	DDESS CITY S	STATE, ZIP CODE	J OZI	20/2021
				TH BADGER			
CALEDO	NIA REHABILITATION	N & RETIREMENT		NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 480	Continued From pa	ige 4		2 480			
	accounting principle	ds and failed to follo es for the accounts. dents who had reside by the facility.	This				
	Findings include:						
		on 2/22/21, at 6:51 received a quarterly facility.					
	the business office had a personal trus indicated R10 was stated the personal sent out on a quart stated the previous was the 1/16/21 an unable to determine	on 02/25/21, at 11:2 manager (BOM) stated account with the fact admitted 7/2/2020. If funds statements we erly statement. The BOM's last day at the dindicated she had at the last time the preparation.	ted R10 acility and The BOM vere to be BOM ane facility been revious				
	the administrator are last week quarterly sent to residents. The stated the previous were behind on sere and stated they had records of when last sent out to resident resident had trust a unable to determine money was in each stated she was plant the deposit slips to was in each account documentation of desidents.	on 02/25/21, at 12: and BOM stated they statements were not he administrator and person had indicated adding out quarterly statements. The BOM stated accounts and the face at this time how may resident account. Thining to go to the bafigure out how much at from the bank exposits. The BOM see kept in a checking	identified at being d BOM ed they tatements d any ats were 12 current ility was uch the BOM ank to get a money tated the				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING:			_
		00073	B. WING		02/2	26/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 480	Continued From pa	ige 5	2 480			
	the bank was going money transferred account and stated that this afternoon.	g account. The BOM stated g to work with her to get into an interest- bearing she talked to the bank about al funds accounts was				
	requested and not					
	Administrator or de and procedures rel of resident account statements are pro assurance committ	THOD OF CORRECTION: The signee could create policies ated to financial management is to ensure quarterly vided to residents. Quality ee could audit for compliance. R CORRECTION: Twenty-one				
2 485	. , .	5 Deposit of Personal Funds	2 485			4/14/21
	under Minnesota S deposit a resident's \$100 in an interest accounts) that is se nursing home's ope credits all interest e account to the resid	accept for veterans homes tatutes, section 198.265, must be personal funds in excess of bearing account (or eparate from any of the erating accounts, and that earned on the resident's dent's account. Pooled arately account for each				
	by: Based on interview facility failed to provesident fund account R12, R28, R138) re	ent is not met as evidenced and document review, the vide quarterly statements for unts for 4 of 4 residents (R10, eviewed. In addition, the ntain a separate accounting of		Corrected.		

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION :	(X3) DATE COMF	SURVEY PLETED
		00073	B. WING			C 26/2021
	PROVIDER OR SUPPLIER	A & RETIREMENT 425 NC	ADDRESS, CITY, S RTH BADGER ONIA, MN 559	STREET	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 485	each resident's fundaccounting principle affected all 12 residuaccounts overseen. Findings include: During an interview stated they had not statement from the. During an interview the business office had a personal trus indicated R10 was stated the personal sent out on a quarte stated the previous was the 1/16/21 an unable to determine BOM had sent out on the administrator at last week quarterly sent to residents. The stated they had records of when last sent out to resident resident had trust a unable to determine money was in each stated she was plant accounts of the stated she was plant accounts over the stated she was plant acc	ds and failed to follow es for the accounts. This lents who had resident fund by the facility. on 2/22/21, at 6:51 p.m. R1 received a quarterly	d d d d d d d d d d d d d d d d d d d			
		nt from the bank eposits. The BOM stated the e kept in a checking account	;			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00073	B. WING			6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 485	Continued From pa	ige 7	2 485			
	the bank was going money transferred account and stated that this afternoon.	g account. The BOM stated g to work with her to get into an interest- bearing she talked to the bank about				
ı	requested and not					
	The administrator of that interest on personal fund accordance of the that interest on personal fundamental	THOD OF CORRECTION: could educate accounting staff sonal funds is a requirement. developed to audit the ensure interest is earned for unts. The result of this could quality assurance committee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 685	MN Rule 4658.0469 Discharge, and Dea		2 685			4/14/21
	transferred or disch than death, the nur discharge summary time of transfer or o	charge. When a resident is narged for any reason other sing home must compile a y that includes the date and discharge, reason for transfer fer or discharge diagnoses,				
	by: Based on interview facility failed to com	ent is not met as evidenced and document review the applete a comprehensive by for 1 of 1 resident (R36) arge.		Corrected.		
	Findings include:					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
		00073	B. WING		02/2) 6/2021
NAME OF I					02/2	0/2021
	PROVIDER OR SUPPLIER	425 NORT	TH BADGER	STATE, ZIP CODE STREET		
CALEDO	NIA REHABILITATION	N & RETIREMENT	NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 685	Continued From pa	ge 8	2 685			
	facility of 11/30/20 hypertension (high history of diabetic for Review of R36's dia 12/16/20, indicated of Hotel], would have the company that we discharge instruction and verbal education reviewing the medit (MAR) and treatment with R36. The discharge not signed by not include copies of R36's discharge instruction cognitive patterns, behavior patterns,	dentified an admission date to with diagnoses including blood pressure), personal cot ulcer and diabetes. Scharge instructions dated R36 discharged to the [name we Home Services and listed would provide services. The construction indicated written, on was completed by cation administration record (TAR) marge instructions provided the resident or family and did of medications, MAR, or TAR. Structions did not include communication, vision, mood beychosocial well-being, sis and health conditions, skin city pursuit.				
	receptionist stated R36's signed disch	on 2/25/21, at 8:43 a.m. the was unable to find a copy of arge instructions and d to R36 upon discharge from				
	director of nursing discharge instruction patterns, communic patterns, psychoso diagnosis and heal and activity pursuit management computions a dischargement and a dischargement computer that is a d	on 02/25/21, at 8:45 a.m. the (DON) verified R36's ons did not include cognitive cation, vision, mood behavior cial well-being, continence, th conditions, skin condition, The DON stated the cany was in the process of a summary for the facility to N verified R36's discharge				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00073		B. WING			C 26/2021
	PROVIDER OR SUPPLIER	J O DETIDEMENT		DRESS, CITY, S	STATE, ZIP CODE STREET		
CALEDO	MIA REHABILITATION	N & RETIREWIENT	CALEDO	NIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 685	instructions did not regulation. The Transfer and D AMA[against medicincluded, Anticipatinitiated by the residence of the interest of the int	meet the requirement of the provided and the resident of illness/treatment of illness/treatment of care that is dependent of the resident of the resident of illness/treatment of	ted 2020 harges- ns for completes mary. The of le cludes, des or therapy. ation cations cations veloped d the ssist the gust be fe and acility, in a tances, ous at to the	2 685			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY PLETED		
		00073		B. WING			C 26/2021
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE	•	
CALEDO	NIA REHABILITATION	N & RETIREMENT		TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 685	The comprehensive shall contain the reand desired outcom with the discharge. Supporting docume of the resident's or verbal or written no facility, a discharge discussions with the representative. SUGGESTED MET The director of nurs develop, review, an procedures regardi DON or designee of systems to ensure report the results to committee for further	e, person-centered of sident's goal for admines and shall be in a sentation shall include resident's representatice of the intent to lead to plan, and document to resident and/or resident and/or resident and/or resident and/or resident and/or revise policies and develop monitor ongoing compliance to the quality assurant ar recommendations a CORRECTION: To	nission alignment e evidence ative's eave the ted sident CTION: nee could and ary. The oring and ce s. wenty-one	2 685			4/14/21
2 000	Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des and 4658.0405. A be out of bed as muis a written order from the comprehensive plan of care as designed and 4658.0405.	general. A resident e and treatment, per supervision based of preferences as idea resident assessment ascribed in parts 4658 nursing home resident as possible unlead the attending physist remain in bed or	must rsonal and on entified in and 3.0400 ent must ss there ysician	2 000			4/14/21

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00073		B. WING		02/2	6/2021
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	& RETIREMENT		TH BADGER NIA, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 830	Continued From page 11			2 830			
	by: FALLS Based on observatireview, the facility fassess each fall, iddetermine the reasopotential effective ir risk for future falls frequency for a service of the facility of 2/12/21 altered mental state.	d on 02/23/21, at 3:3 of her bed, gripper so didentified an admiss with diagnoses inclus, avoidant persona	ocument ively ors to iffy ease the R137, 2 p.m. ocks, tray ion date uding lity		Corrected.		
	disorder. R137's Fall Risk As indicated R137 was a score of 13. R137's fall care pla falls r/t [related due safety needs. Goals free of falls through included, "Anticipat need. Be sure the r reach and encourage assistance as need prompt response to Follow facility fall president of the state of the st	sessment dated 2/1: s at moderate risk for n included, "I am at I deconditioning, una s include, "The resident he review date. Into e and meet the residesident's call light is ge the resident to us led. The resident need all requests for assistant of the resident of the resident need all requests for assistant need all requests for assistant need as ordered or PRN [a	5/21 r fall with risk for aware of ent will be erventions dent's within e it for eds istance. Therapy]				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING	·		,
		00073	B. WING		02/2	26/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	RTH BADGER ONIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 12	2 830			
	needed]."					
	R137's progress not p.m. included, "Res nursing assistant] an ight "when it was approached her stabathroom at 0330-CLeft then fell to the and back to bed no Now c/o [complaini of back. No redness stable]. Admits hav to call for assist wit will pee my pants". call right away for sell right away for sell investigation or meeting review of the During an interview director of nursing (been made aware overified there was reinterdisciplinary teastated the fall intervent R137 to call for assented the fall intervent R137's fall when a documentation of the licensed practical in document on the fall of the state of the process.	cord lacked documentation of an interdisciplinary team his fall. If on 2/24/21, at 12:53 p.m. the discrete product of R137's fall. The DON and a fall investigation or an arm review of the fall. The DOW rention was to encourage sistance per the progress parified she became aware of	e ed de e e e e e e e e e e e e e e e e			
	LPN-A stated when	on 02/24/21, at 1:15 p.m. there is an unwitnessed fall ds the resident completes a	,			

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winnesc	ota Department of He	eaith				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE : COMPL	SURVEY LETED
		00073	B. WING		02/2	6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	ONIA REHABILITATION	N & RETIREMENT 425 NORT	TH BADGER NIA, MN 559	STREET		
		CALEDOI	VIA, IVIIV 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	fall investigation. Lidetermine the root and family member a progress note regeverything you hav told the CNA (certif between 11:30 a.m during the night. The assistant) reported there and asked he stated R137 told modern bathroom, that it was to lean and then whell the opposite was instructed R137 to have a fall to let stated she did not form. LPN-A stated happened during the what had happened the protocol was for stated she did not reabout the fall. LPN-when this was goin not quite sure how probably should haverified did not followed falls and stated that her before when so hours earlier. R24 During an observat R24 laid in bed with R24's call light was bed was in low pos	PN-A stated we need to try to cause of the fall. The provider are contacted, and you make garding the incident regarding the done. LPN-A stated R137 ied nursing assistant) she fell and 12:00 p.m. that she fell are CNA (certified nursing to LPN-A and she went in the what happened. LPN-A eshe had got up to go to the as dark, she stood up started then she tried to stand up, she way. LPN-A stated she call for assist and if she did off know right away. LPN-A ill out the fall investigation she did not do one because it the night and she was not sure what or something like that. LPN-A thotify the provider or the family and stated she was also to handle it. LPN-A stated she we filled out the form. LPN-A thotify the provider or the family and she was not sure of the handle it. LPN-A stated she was also to handle it. LPN-A stated she was also to handle it. LPN-A stated she we filled out the form. LPN-A the facility procedure for this has never happened to be mebody stated they had fallen in on 2/22/2021, at 3:04 p.m. In his eyes closed and snoring. I aced around bed grab bar, ition, and fall mat was next to be lechair was close to the edge				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00073		B. WING			C 26/2021
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 02/1	10/1021
CALEDO	NIA REHABILITATION	I & DETIDEMENT		TH BADGER			
CALEDO	MIA REHABILITATION	N & RETIREWENT	CALEDON	NIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From page 14			2 830			
	unsteadiness on fer anxiety disorder, alt dementia with beha abnormalities of ga R24's annual Minim assessment dated severe cognitive im MDS identified R24 assistance from one transfers, and toilet	num Data Set (MDS) 1/6/2021, indicated I pairment and delusi required extensive e staff for bed mobili ing.	on, cataract, and) R24 had ons. The ty,				
	assessment was co	rd identified the last ompleted on 11/20/2 ed R24 was at high	020. The				
	physical mobility re and musculoskeleta also included, "is at dementia, inability to ambulate. Associthe following; -Education with wife 1/3/2020) -Be sure residents encourage use, and response to all requivalenceds meaningful potential for falls which distraction. Offer to date 2/30/2019)non-skid strips in fifloor start date 10/2	entified R24 had limilated to weakness, of all impairments. The price risk for falls r/t [related transfer self safely iated interventions in the regarding visits (stansfer self safely iated interventions in the regarding visits (stansfer self light is within read resident needs products for assistance as (start date 2/12/20 activities that minimalle providing diversionally down after activitient of resident reclinations, before bed,	dementia, care plan ted to] y, inability ncluded art date ach, empt (start date on and ities (start dart date)				

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	IDENTIFICATION NUM	IBER:		E CONSTRUCTION		SURVEY PLETED
	00073		B. WING			C 2 6/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADI	DRESS. CITY. S	STATE, ZIP CODE	1 02/2	0/2021
CALEDONIA REHABILITATION	& RETIREMENT		H BADGER			
CALLDONIA KLITADILITATION	& KETIKLINILIAT	CALEDON	NIA, MN 559			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY F IC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 830 Continued From pag	ge 15		2 830			
and after meals and resident unattended 3/17/2020) -Place resident's wh close to him when he 3/17/2020) -Bed in lowest positi date (1/3/2020) Facility incident reporate p.m. included R24's was documented as you kids to come he referring to staff as he Immediate Action Tasigns] obtained and light within reach, en assistance, supervise throughout the shift, remainder of the form causal factors, root of interventions was black R24's corresponding 11/20/2020, at 2:56 noted on floor mat a assessed resident a motion] intact VSS [normal limits], alert probserved at this time placed with easy realight, at this time bed of physician] and far R24's record did not root cause analysis, interdisciplinary tear	at 10 p.m. Do not le on the toilet (start da neelchair across the re isn't in the chair (start date) at the chair date (start date) a	room- not tart date ed start at 12:21 II which vanted ital bed, call quest for ess." The tential dent ter of [within njury call light use call it, [name iton of				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00073	B. WING			, 6/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	TATE, ZIP CODE		
CALEDO	NIA REHABILITATION	I & RETIREMENT	H BADGER			
	011111111111111111111111111111111111111		IIA, MN 559		211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 16	2 830			
	nursing assistant (N for falls. NA-D indic between good days indicated R24 had and would not use anticipate his needs had his sleepy days check on him at lea R24's bed needed the floor mat down, wheelchair near the case R24 did get up walk to his chair.	NA)-D stated R24 was at risk rated R24 seemed to cycle and bad days. NA-D days where he was impulsive his call light and staff had to s. NA-D indicated when R24 is he would make sure to list every 2 hours. NA-D stated to be in the lowest position, call light in place, and his is bed with the breaks locked in the houldn't have so far to a con 2/25/2021, at 4:59 p.m.				
	During an interview on 2/25/2021, at 4:59 p.m. director of nursing (DON) reviewed R24's record and incident report and confirmed the incident report lacked an investigation into causal factors, determination of root cause, IDT involvement and review/revision of the care plan; DON stated those tasks should have been completed. DON also stated reminding R24 to remember to use his call light was not an appropriate intervention for him because he did not consistently remember to use the call light.					
	12/2007 included, conjunction with the consultant pharmac will seek to identify factors for falls. The staff will look to between the onset episodes) and recemedication regimer. The assessment dates.	ata shall be used to identify conditions that may increase				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
	00073		B. WING			C 26/2021	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	02//	20/2021
	NIA REHABILITATION	J & DETIDEMENT		TH BADGER			
CALEDO				NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17		2 830			
	The staff with supposed will evaluate function that may increase for the staff will seek to factors that may coolighting and room late to identify and addrand interventions to	ort of the attending ponal and psychologicall risk, o identify environmentribute to falling, surayout. ding physician will coress modifiable fall rise try to minimize the sk factors that are no	al factors ntal ch as ollaborate sk factors				
	review the facility fa assess, monitor, ar	ion, interview, and do ailed to comprehensin nd treat a worsening dents (R138) reviewe	vely pressure				
	During an observat R138 laid on his bat (NA)-F and NA-G at incontinent brief. But not aware of any with bottom. When NA's were no wounds probuttocks were observated a coccyx wou open wound that with nickel. R138 denied related to the impait nursing (DON) entergresences of both with measurements; DC	ion on 2/24/2021, at ack in bed. Nursing a assisted R138 with choth NA's indicated thounds present on R1 cleaned R138 and sesent, however whereved, R138 was obsind and a inner left glas approximately the distribution having discomfort or red skin integrity. Direct the room, confirmation of the room of the room, confirmation of t	ssistant nanging ey were 138's said there n R138's erved to luteal fold e size of a pr pain rector of med the dund was a				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
						С	
		00073		B. WING		02/2	26/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CALEDO	NIA REHABILITATION	& RETIREMENT		TH BADGER NA, MN 559:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 18		2 830			
		ind was a superficial cm in circumference					
	admitted to the faci	Record, indicated R1 lity on 2/12/2021, wi uded obesity, diabet	th				
	2/12/2021, section	mit Assessment dat labeled Skin Integrit I a pressure ulcer to her information.	У,				
	plan dated 2/12/202 impaired skin integrit did not address the R138's activities of 2/15/2021, indicate assist for toileting a mobility, R138 coulbowel and bladder 2/15/2021, included hours and assist with Provide pericare after R138's diabetic carroll of body for break as ordered by doctor "Monitor/document."	aseline care plan and 21 identified that R13 rity related to a surgine sacral pressure and daily living care pland transfers, and bed reposition himself. Incontinence care pland "check resident eventh toileting as needed the each incontinent e plan directed staff as in skin and treat por" and "report to MD PRN [agn/symptoms] of inference 21 identified as in skin and treat por" and [agn/symptoms] of inference 21 identified as in skin and treat por" and [agn/symptoms] of inference 21 identified as in skin and treat por" and [agn/symptoms] of inference 22 identified as in skin and treat por" and [agn/symptoms] of inference 22 identified as i	38 had cal wound rea. 1 dated e staff d R138's an dated ery two d. episode." to "Check romptly				
	2/18/2021, identified ulcer however, did in The assessment in centimeters (cm) x	und Assessment dat d that R138 had a sa not identify the stage cluded ulcer measur 0.5 cm, no depth wa issessment did not in	e of ulcer. es of 0.2				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		SURVEY PLETED
	00073		B. WING			C 26/2021
NAME OF	PROVIDER OR SUPPLIER		T ADDRESS, CITY,	STATE, ZIP CODE	UZI	LO/LOL 1
CALEDO	NIA REHABILITATION	I X RETIREMENT	ORTH BADGER DONIA, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
	include a specific tr to treat.	eatment plan or interventio	ns			
	p.m. included, "a sp person]. Butt asses received to clean cl saline]. Pat dry. Ap Cover with 2 x 2 [ga	ote dated 2/24/2021, at 2:39 pecial visit with [name of esment completed. Orders leanse with NS [normal ply skin prep to periwound. auze]- cover with tape. Twivider if drainage present."				
	p.m. included, "Typ "sacral midline- 0.1 visualize the base of observed from wou practitioner]. Reside was not authored be measured the wour not consistent with	note dated 2/24/2021, at 2 e of Wound: unknown" and x 0.1 x 0.2 cm- unable to of wound. No drainage nd. Special visit for NP [nuent denies pain." The note y the DON who physically nd; the measurements were measurements stated by the wound was assessed.	rse			
	4:16 p.m. did not in assessment and or pressure 0.2 x 0.5 [essment dated 2/24/2021, clude the sacral ulcer aly identified "left buttock [cm]." Stage of the left butto not identified on the				
		ion on 2/24/2021, at 6:58 a ck with the head of the bed				
	2/24/2021, at 8:00 at the same position.	and observation on a.m. R138 continued to lay Licensed practical nurse did not have any pressure n.	in			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			71. BOILDING.			;
		00073	B. WING			6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NA, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
2 830	Continued From pa	ge 20	2 830			
	R138 continued to unidentified nursing room and assisted breakfast. During a 9:00 a.m. the NA ha continued to be in t	and observation on				
	back with the head stated she had just and had not reposit NA-F stated R138 on not done anything of assisting him with like	a.m. R138 laid in bed on his of the bed elevated. NA-F finished feeding him lunch tioned R138 before or after. wasn't feeling well today, had with him prior to or after unch, and stated he let us ded something, however oddly in his light at all so far.				
	NA-F stated her an between 6:00 a.m. wet and had not pu we (NA-F and NA-0 11:15-11:30 a.m., b well that morning; NA's both confirme and 11:15-11:30, R and/or offered repoput on his call light, really long time apaasked how often R repositioned, neither often R138 should	·				
	director of nursing (record, confirmed to	on 2/25/2021, at 11:41 a.m. (DON) reviewed R138's he admission assessment was lcer had worsened since				

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AND BLAN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		A. BUILDING:			,	
		00073	B. WING		02/2	6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	measured on 2/18// plan. DON confirms system in place to a turning and repositi prevent pressure undeterioration of exis nursing assistance R138 according to two hours; If reside expectation was to re-approach. Facility policy Press dated 2/2014 include procedure is to pro- assessment and id- of developing press -Assessment: 2. Sk assessed for the pro- pressure ulcers on frequently if indicate perform routine skin b) nurses are to be changes are identifi risk can develop a hours of onset of pro- needs to be identifi implemented promipressure ulcers. The define those initial of interventions. Facility policy Press Breakdown-Clinical included: The nurse shall des the following: Full a including location, so including location, so	2021, and lacked a treatment ed the facility did not have a determine and individualized ioning schedule in order to leers and/or prevent sting ulcers. DON stated the should have repositioned the care plan or at least every nts refused positioning the document the refusal and sure Ulcer Risk Assessment ded, the purpose of this vide guidelines for the entification of residents at risk sure ulcers. Assessment. Skin will be resence of developing a weekly basis or more ed. 3. Monitoring: staff will in inspections (with daily care), notified to inspect skin if skin fied. 4) because a resident at pressure ulcer within 2-6 ressure, the at risk resident ed an have interventions ptly to attempt to prevent he admission evaluation helps care plan approaches and	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		SURVEY PLETED		
			D WING			С	
		00073		B. WING		02/	26/2021
NAME OF I	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT		NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 22		2 830			
	The staff will exami	, including support so ne the skin of a new ations or alterations					
	R23						
	assessment, dated had moderately imp supervision with ea identified a diagnos	imum Data Set (MD 1/5/21, indicated the paired cognition and ting. The MDS furthesis of end stage rena- ared dialysis services.	e resident required er I disease				
	R23's care plan, included a potential nutritional problem related to diet restriction for end stage renal disease and diabetes. Interventions included a 1500 cc (cubic centimeter) fluid restriction.						
		ian orders, included c's per day, with an c					
	Record (MAR), and Record (TAR) printe	edication Administrat I Treatment Administ ed 2/25/21, and date lude evidence of fluiong ng staff.	ration d 2/1/21 -				
	R23's Dietary Card Fluid Restriction, 24	, printed 2/25/21, ind 40 cc per meal.	licated:				
	the dietary manage	itled, Water Pass, pr r (DM), indicated R1 on with each water p	was on a				
	a 1200 cc fluid rest	p.m. R23 confirmed riction and stated, "B enever I ask for it". F	But they				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED		
	00072		B. WING			C	
		00073				021	26/2021
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	& RETIREMENT		TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 23		2 830			
	not sure if staff were shared one night ha overnight staff gave didn't think I was su On 2/24/21, at 12:1	e tracking her fluid in ad asked for water a her a large mug, "I apposed to have all t 4 p.m. R23 was obs ch. The meal includ	nd the told staff I hat." served in				
	in an 8 ounce cup (240 cc) with a cover no other fluids includ	and				
	confirmed activity s at times for residen	p.m. activities aide taff could provide be ts. AA-B stated ther ne knew of that was lent was not	verages e was				
	review the facility fa systems for monitor residents (R13 and failed to ensure the monitored and asse- treatment, and faile	on, interview and do illed to implement ac- ring fluid intake for 2 R23). In addition, th dialysis access site essed upon return to d to notify the dialys te was bleeding for iewed for dialysis.	dequate of 2 e facility was dialysis is center				
	Findings include:						
		ecord, included diag ease, dependence o tial hypertension.					
	assessment dated R13's cognition. Th	num Data Set (MDS) 12/6/2020, did not id e MDS indicated R1 activities of daily livi	entify 3 required				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE : COMPL		
		00073	B. WING		02/2) 6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	STATE, ZIP CODE		
		425 NOR	TH BADGER			
CALEDO	ONIA REHABILITATION	V & RETIKEMENT CALEDO	NIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 24	2 830			
	included record and weigh resident per weights. The hydra identified R13 was potential fluid deficistools; associated in educate resident/faintake, offer drinks ensure all beverage diet/fluid restrictions requirements, moniand monitor and doper facility policy. Remodialysis dated following: Check araccess site. Docum as ordered, palpate use stethoscope to blood flow through dialysis on Monday there is a major ble apply pressure to in emergency service medical emergency until emergency service medical emergency service medical emergency service is until emergency service is a major ble apply pressure to in emergency service medical emergency service medical emergency service is until emergency service medical em	aitor for signs of dehydration, ocument intake and output as R13's care plan for d 9/13/2019, directed the end change dressing daily at ment. Check patency of the site to feel the thrill or the hear the whoosh or bruit of the access, R13 received y, Wednesday, and Fridays. If the eding form site (post dialysis), insertion site and contact is and dialysis center. This is a sy. Do not leave resident alone ervices arrive. The report as needed for the bleeding, hemorrhage, shock. Resident has an AV er arm, resident is on a 1.5 and resident receives the of dialysis clinic].				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00073		B. WING		02/2	6/2021
	PROVIDER OR SUPPLIER	STREET ADI	H BADGER			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	minutes pressure, to occurs, send patier shift on Monday, W 3/13/2020) -Check for presence shift notify physicia 2/28/2020) -Document dry weig dialysis obtain weig 2/12/2021) -Ensure resident has supplies (start date -Fluid restriction 15-Furosemide 40 mg (start date 8/29/201) During an interview R13 sat up in his w stated he received Wednesday, and Farm where his dialy raised area on his so (no bleeding observatiff had not check when he arrived bastaff did not always R13's progress not at 1:39 p.m. include from R [right] arm a amount of bright bloblood on soiled dre applied and when resing and is no did not identify apploss, how long the start of the start o	then recheck. If bleeding still at to the ER every evening rednesday, Friday (start date e of bruit/thrill- right arm every if absent (start date ghts when returning from the from dialysis (start date as dialysis bag with dialysis 9/10/2020) and (milliliters) per day. (milligrams) two times a day 19). Ton 2/22/2021, at 6:37 p.m. heelchair in his room. R13 dialysis on Monday, riday. R13 pointed to his right rais port was located; was a shirt from underlying bandage wed through shirt). R13 stated ed the bandage for bleeding ck at the facility, and stated check after the appointment. The dated 1/5/2021 (Tuesday), and "When dressing removed area this morning small bod oozing from fistula. No ssing. Another dressing now removed no ne [sic] on longer bleeding. R13 record roximate amount of blood site was bleeding, how long ed, and lacked evidence of	2 830			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			,			;
		00073	B. WING			6/2021
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	'H BADGER IIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 26	2 830			
	a.m. included, "No prior to leaving for after dressing remo	e dated 1/6/2021, at 10:45 bleeding form fistula R arm dialysis. No signs of bleeding oved yesterday."				
	R13's dialysis clinic 1/6/2021. R13's dia included "Patient re nursing home. Patie after the staff took to that it bled a large a pressure held for a how long. Gauze w	c and obtained records from alysis note dated 1/6/2021, eported fistula bleeding at ent stated it started yesterday the gauze dressing off and amount and needed manual "long time". Unable to say trap was replaced and taken tent reported it was still leaking				
	reviewed from 1/4/2	munication notebook was 2021 to 1/6/2021, no entries ing to R13's dialysis site				
	licensed practical name the nurse working with bleeding and wrote stated that morning and thrill, there had the site was drippin applied a gauze probleeding, and where only a small amount the bleeding had state thought she had reminutes. LPN-A state dialysis of the bleed large amount and the state of th	on 2/25/2021, at 9:06 a.m. nurse (LPN)-A stated she was when R13's dialysis site was the progress note. LPN-A is she went in to check for bruit I not been a bandage on, and ing blood. LPN-A stated she essure dressing to stop the in she came back there was int of blood on the dressing and copped. LPN-A stated she checked the site after 30 inted she had not notified ding because it was not a she bleeding stopped.				
	During an interview	on 2/25/2021, at 8:29 a.m.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		00073		B. WING			C 02/26/2021	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•		
CALEDO	NIA REHABILITATION	& RETIREMENT		TH BADGER NA, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 830	dialysis registered in R13's care manage notes dated 1/6/202 beginning of treatm had any post bleed of telling us and waknowledgeable wheread the visit note a stated the facility has ite had post bleed depend on the amoreonsidered an emesupposed to apply bleeding; stated the us of any bleeding it down it the command forth. R13's January and administration recophysician orders for intake values ranger. R13's January and administration recophysician orders for intake values ranger. R13's January and administration recophysician orders for intake values ranger. R13's record the check the check marked boxed completed on every included the physic restriction, however with no fluid intake. R13's record identification in two are intake. The record with each other, an of evaluation/asses hour intake. Examples	nurse (DRN) stated er. DRN reviewed R. 21, and stated at the ent patients are asking issues; R13 was a reliable historiar en it came to his dial aloud from 1/6/2021, ad not communicate ing. DRN stated it wount of bleeding if it vergency. DRN stated pressure if they note a facility should have either via phone or bunication book that record (MAR) identified for the Arginaid; recorded from 60 ml to 240 February 2021 treated from 60 ml to 240 February 2021 treated (TAR) identified profistula; the boxes have indicating the task of dialysis day. The Trian order for 1500 mm all of the boxes have amount recorded.	13's visit e ded if they s capable n and lysis. DRN n, and ed R13's rould was I staff were ed e notified by writing goes back lication the ded fluid o ml. tment bhysician ad a k was 'ARs also nl fluid d an "X", s being nd "fluid consistent evidence nty-four	2 830				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET LODGE A BUILDING: B. WING C Q2//26/2021 NAME OF PROVIDER OR SUPPLIER STREET CALEDONIA, MN 55921 425 NORTH BADGER STREET CALEDONIA, MN 55921 PROVIDER'S PLAN OF CORRECTION (EACH ORDINACY MUST BE PRECIDED BY PULL RESULATORY OR LS: IDENTIFINE INFORMATION) PREFIX PAG CROSS REFERENCED FOTHE APPROPRIATE 2 830 Continued From page 28 three boxes were blank; corresponding Meal intake for 2/20/21, indicated R13 consumed 240 ml for breakfast, lunch box was left blank, R13 consumed 240 ml for dinner. The MAR Arginaid consumption; R13 consumed 120 ml in the morning and evening. -Fluid intake documentation for 2/21/2021 two boxes were left blank and Va Doxes had "0"; corresponding Meal intake for 2/22/21/201, had blank box for breakfast intake, lunch intake was 240 ml, and dinner intake was 120 ml. The MAR Arginaid consumption was 120 ml in the morning and evening. -Fluid intake documentation for 2/22/2021, two boxes were left blank and two boxes had "0"; corresponding Meal intake for 2/22/2021, had 240 ml for breakfast, a blank box for lunch, and 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. -Fluid intake documentation for 2/23/2021, two boxes had "0" recorded and one box was blank; corresponding Meal intake for 2/23/2021, had blank box for breakfast, 240 ml for funch, and 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. During an interview on 2/24/2021, at 2.31 p.m. registered nurse (RN)-B stated nurses are documenting fluid intake on the TAR's. RN-B reviewed the areas in R13's record where fluid intake was documented and stated it could not be determined how much fluid intake R13 consumed on a daily basis. RN-B's stated the dietician would be a good person to evaluate daily fluid totals.		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT TAG CALEDONIA REHABILITATION & RETIREMENT CALEDONIA MN 55921 2 830 Continued From page 28 three boxes were blank; corresponding Meal intake for 2/2021/2, indicated R13 consumed 240 ml for breakfast, lunch box was left blank, R13 consumed 240 ml for breakfast, lunch box was left blank, R13 consumed 120 ml in the morning and evening. -Fluid intake documentation for 2/21/2021- two boxes were left blank and 3rd box had 240 ml recorded; corresponding Meal intake for 2/2021/2, had blank box for breakfast, a blank box for lunch, and 240 ml for drinner. The MAR arginaid consumption was 240 ml and the morning. -Fluid intake documentation for 2/22/2021, two boxes were left blank and 8rd box had 240 ml recorded; corresponding Meal intake for 2/221/2021, had 240 ml for drinner. The MAR arginaid consumption was 120 ml in the morning and evening. -Fluid intake documentation for 2/22/2021, had 240 ml for drinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. -Fluid intake documentation for 2/23/2021, had blank box for breakfast, a blank box for lunch, and 240 ml for drinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. -Fluid intake documentation for 2/23/2021, had blank box for breakfast, 240 ml for funner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. -Fluid intake documentation for 2/23/2021, had blank box for breakfast, 240 ml for funner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. -Fluid intake was documented and stated it could not be determined how much fluid intake on the TAR's. RN-B reviewed the areas in R13's record where fluid intake was documented and stated it could not be determined how much fluid intake on the determined how much fluid intake on the determined how much fluid intake R13 consumed to a daily basis.	712 . 271	0. 00	.5	A. BUILDING:			
CALEDONIA REHABILITATION & RETIREMENT (X4) ID PREFEX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 28 three boxes were blank; corresponding Meal intake for 2/20/21, indicated R13 consumed 240 ml for breakfast, lunch box was left blank, R13 consumed 240 ml recorded; corresponding Meal intake for 2/20/21, indicated R13 consumed 240 ml recorded; corresponding Meal intake for 2/21/2021, had blank box for breakfast intake, lunch intake was 240 ml, and dinner intake was 120 ml. The MAR Arginaid consumption was 120 ml in the morning and evening. -Fluid intake documentation for 2/22/2021, two boxes were left blank and two boxes had "O"; corresponding Meal intake for 2/22/2021, had blank box for breakfast, a blank box for lunch, and 240 ml for dinner. The MAR Arginaid consumption was 220 ml in the morning and evening. -Fluid intake documentation for 2/22/2021, two boxes were left blank and two boxes had "O"; corresponding Meal intake for 2/22/2021, had 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and evening. -Fluid intake documentation for 2/22/2021, had 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. -Fluid intake documentation for 2/22/2021, had blank box for breakfast, 240 ml for lunch, and 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. -Fluid intake documentation for 2/23/2021, had blank box for breakfast, 240 ml for lunch, and 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. -Fluid intake on the TAR's. RN-B reviewed the areas in R13's record where fluid intake on the TAR's. RN-B reviewed the areas in R13's record where fluid intake on the determined how much fluid intake not be agood person to evaluate			00073	B. WING			
CALEDONIA, MN 55921 CALEDONIA, MN 55921	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 28 three boxes were blank; corresponding Meal intake for 2/20/21, indicated R13 consumed 240 ml for breakfast, lunch box was left blank, R13 consumed 240 ml for breakfast, lunch box was left blank, R13 consumed 240 ml for obxes were left blank and 3rd box had 240 ml recorded; corresponding Meal intake for 2/21/2021, had blank box for breakfast intake, lunch intake was 240 ml, and dinner intake was 120 ml. The MAR arginaid consumption for 2/22/2021, two boxes were left blank and two boxes had "0"; corresponding Meal intake for 2/22/2021, had 240 ml for dinner. The MAR arginaid consumption was 120 ml in the morning and evening. -Fluid intake documentation for 2/23/2021, had 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. -Fluid intake documentation for 2/23/2021, had blank box for breakfast, a blank box for breakfast, a blank box for breakfast, a blank box for lunch, and 240 ml for dinner. The MAR arginaid consumption was 240 ml in the morning and 60 ml in the evening. During an interview on 2/24/2021, at 2:31 p.m. registered nurse (RN)-B stated nurses are documenting fluid intake on the TAR's. RN-B reviewed the areas in R13's record where fluid intake was documented and stated it could not be determined how much fluid intake R13 consumed on a daily basis. RN-B stated the dietician would be a good person to evaluate	CALEDO	NIA REHABILITATION	N & RETIREMENT				
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During an interview on 2/24/2021, at 2:38 p.m.	2 830	three boxes were be intake for 2/20/21, iml for breakfast, lur consumed 240 ml from consumption; R13 morning and evening. Fluid intake documboxes were left bla recorded; corresponding the corresponding to the corresponding Mean 240 ml for breakfast 240 ml for dinner. In consumption was 250 ml in the evening. Fluid intake documboxes had "0" reconsumption was 250 ml in the evening. During an interview registered nurse (Redocumenting fluid in reviewed the areas intake was docume be determined how consumed on a daid dietician would be a daily fluid totals.	plank; corresponding Meal indicated R13 consumed 240 meh box was left blank, R13 for dinner. The MAR Arginaid consumed 120 ml in the mg. The mentation for 2/21/2021- two mk and 3rd box had 240 ml mding Meal intake for mk box for breakfast intake, 40 ml, and dinner intake was arginaid consumption was 120 ml evening. The matter of 2/22/2021, two mk and two boxes had "0"; all intake for 2/22/2021, had st, a blank box for lunch, and the MAR arginaid 240 ml in the morning and 60 mentation for 2/23/2021, two rded and one box was blank; all intake for 2/23/2021, had fast, 240 ml for lunch, and the MAR arginaid 240 ml in the morning and 60 mentation for 2/23/2021, had fast, 240 ml for lunch, and the MAR arginaid 240 ml in the morning and 60 mentation for 2/24/2021, at 2:31 p.m. RN)-B stated nurses are make on the TAR's. RN-B in R13's record where fluid ented and stated it could not much fluid intake R13 much fluid intake R13 me good person to evaluate	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00073	B. WING		02/2	6/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 29	2 830			
		staff recorded fluid intake in they picked up meal trays.				
	NA-J stated she us stated dietary staff intake in the compustaff did not have the would record it for the record any other into was provided with runawareness of whamount of fluid intated nursing assistant (Note in the interview of the intervie	on 2/26/2021, at 8:51 a.m. assistant (TMA)-A stated nedications she did not record intake and dietary staff				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		_	,
		00073	B. WING		02/2	6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	director of nursing of did not identify dialy when R13's dialysis should have been a dialysis communicate there should have be how/when the site of and expected staff according to physic R13's fluid intakes a have a solid way fluid documented and evenot being complete. During an interview certified dietary mainterview certified dieta	on 2/25/2021, at 11:22 a.m. (DON) confirmed the record ysis or provider was contacted as site was bleeding, and they and/or should have been in the ation book. DON indicated been documentation of was monitored for bleeding check the site after dialysis cian orders. DON reviewed and stated the facility did not uid intakes were being valuation of the intakes was	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00073		B. WING			C 26/2021
NAME OF	PROVIDER OR SUPPLIER		REET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	I & RETIREMENT		TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	fluid restriction as d much where R23 re On 2/25/21, at 1:35 (LPN)-A stated to h	g unaware if R23 was or lidn't work the east wing esided. p.m. licensed practical er knowledge, R23 was n. LPN-A further stated	very				
	monitored what fluid on a fluid restriction fluids they administ LPN-A reviewed R2 confirmed R23 was restriction. When a document R23's flu "Good question". Land TAR and confir fluid intake by nursi		onitor R. d l uld ided, IAR ing of				
	(DM) confirmed die passing out water to documenting how me residents on a fluid does the water passing who was on a fluid could receive. Diet much fluid was con it was around 240 cresident requested couldn't refuse the confirmed the dietic weekly, was resport for resident's on a feducate the resider prescribed. DM correstriction, and furth was recently reduced.	pm. the dietary manage tary staff were responsible or residents and also for nuch water was consum restriction. The staff that is has a sheet that indicates triction and how much ary staff also tracked how sumed at meals, and the co's at each meal, though more fluids than that stresident's request. DM cian, who came to the famisible for tracking fluid in luid restriction and would if consuming more that if consuming more that if consuming more that if consuming the restricted from 1500 cc to 1200 are how nursing staff we	ble for ned for at ated ch they ow ought h if the caff ncility ntake d an uid ction) cc				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				71. BOILBING.		С	
		00073		B. WING		02/2	26/2021
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	& RETIREMENT		'H BADGER IIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 32		2 830			
	notified when a res	ident was on a fluid re	estriction.				
	director of nursing (have been monitori dietary staff's monit	on 2/25/21, at 3:36 p.i (DON) confirmed stating R23's fluid intake storing was not completursing should have bed restriction.	ff should and that ete. DON				
	DM confirmed dieta how much fluid was water pass. DM re meals and confirme consistently docum consumed at each	on 2/26/21, at 9:40 a.mary staff should be changed for each viewed R23's fluid intended staff had not been enting how much fluid meal. A copy of R23' 1 to 2/26/21 was required.	arting meal and ake with d was 's fluid				
	10/2010, included: Mild bleeding from expected. Apply pre- contact dialysis cer If there is major ble dialysis), apply pre- contact emergency Verify that clamps a	eding from the site (p ssure to insertion site services and dialysis are closed on lumens. cy. Do not leave resid) can be e and lost and s center.				
	SKIN INTEGRITY	AND FLUID MONITO	RING				
	review the facility facomprehensive skill integrity of a foot ul residents (R139) re	ion, interview, and do ailed to identify, comp in assessment of impa cers upon admission wiewed for impaired s in, the facility failed to	lete a aired skin for 1 of 2 skin				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00073	B. WING			6/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 33	2 830			
	prescribed fluid resconsistently monitoral residents reviewed congestive heart fathospitalization relations	ntake for a physician triction and failed to are and evaluate edema for 1 of ed (R2) who had a diagnosis of ilure and had a history of ted to fluid overload.				
	Finding include:					
	2/22/2021, at 3:30 R139 stated he wardays ago because groin that needed on the second	ion and interview on p.m. R139 sat on his bed. s admitted to the facility a few of a gangrene infection in his dressing changes that he could elf. When asked if he had any sure ulcers, R139 said he had e bottom of right foot the size to be a big blister. R139 dressing over the wound now ince he had been admitted to s not been changed. R139 some areas on two of his toes he thought were healing. R139 and seen the wounds to his 139 said noone here had ds and had not asked about ditions.				
	been admitted to the diagnoses of diabe	Record, indicated R139 had he facility on 2/20/2021, with tes type 2, Fournier gangrene, pulmonary disease, and				
	2/19/2021, indicate the hospital on 2/8/ 2/19/2021. The sur	charge summary dated d R139 had been admitted to 2021 and discharged on nmary also included tic peripheral neuropathy and				

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STATEMENT OF DEFICIENCE AND PLAN OF CORRECTIO		(X1) PROVIDER/SUPPI		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
				A. BUILDING:		,	,	
		00073		B. WING			26/ 2021	
NAME OF PROVIDER OR SI	JPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CALEDONIA REHABIL	ITATIO	N & RETIREMENT		TH BADGER NIA, MN 559				
PREFIX (EACH DE	FICIENC'	ATEMENT OF DEFICIENC Y MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
the facility's summary id treatment of had ulcerati R139's Adm 2/20/21, in sidentify the identify the identification of identification	neart fallist of centified for the construction in the certain means at 8:52 urse (Figure 139's fange beroom, present fall for the centification in depere was some and the centification in the centi	ailure that was not in diagnoses. The disc I the groin wound a ver did not identify	charge and the that R139 ated and did not R139's feet. In ed, of nursing ange the letion of the were going I RN-A to 19's right around es, removed on on the did the form a vith of a vith	2 830				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
			A. BUILDING:	·		,
		00073	B. WING		02/2	6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 35	2 830			
	Change dressing q	3 days. Vaseline to feet."				
	licensed practical n worked on 2/20/202 to R139's groin how about the impaired During an interview nursing assistant (N cares to R139 the I worked on 2/20/21 NA-E stated she was wound in his groin stated on 2/20/21, sneeded help with a so she had not seed did not ask R139 if impaired skin integrany sores.	on 2/23/2021, at 3:55 p.m. nurse (LPN)-B stated he had 21, had changed the dressing wever did not know anything skin integrity to R139's feet. on 2/23/2021, at 3:59 p.m. NA)-E stated she had provided ast couple of days and had when R139 was admitted. as only aware that R139 had a and nowhere else. NA-E she had asked what R139 nd he wanted his socks left on this feet. NA-E stated she she could inspect his feet for rity and did not ask if he had				
	RN-A stated she ha	on 2/23/2021, at 4:47 p.m. ad not previously been aware R139's feet before today.				
	DON stated she had admission, however nurse she had not a audit and asked that stated she did not found had assumed that it stated she had not wounds to R139's found expected that a full upon admission, ar	on 2/23/2021, at 5:06 p.m. ad completed R139's or reported to the evening shift completed the entire body at the nurse complete it. DON follow-up with the nurse and it had been completed. DON been previously aware of the feet. DON stated it was body audit be completed and indicated staff should be grindependent residents to lits.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILBING.				
		00073	B. WING			6/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NIA, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 36	2 830				
	During an observat R2 sat in his wheel down in the depending grips on to both leg edematous with the stated he was on a thought he had bee facility passed wates ink. R2 stated he help with the swelling 7:00 p.m. to 6:00 a him before breakfasted edema but not daily R2's Admission Rechypertensive heart with heart failure, a R2's scheduled (PF assessment dated not have cognitive in was not administered R2's physician order 1/28/2021) - Tubi grips- on in the dema (start date 1/28/2021) - Tubi grips- on in the dema (start date 1/28/2021) - Tubi grips- on in the dema (start date 1/28/2021) - Tousemide (diuretticongestive heart face)	ion on 2/26/21, at 8:42 a.m. chair in his room with his legs dent position. R2 had tubi s, both legs observed to be eright worse than the left. R2 1.5 liter fluid restriction, and en following. R2 stated that the er and their was water in the elevated his legs at night to ng, and were up in the air from m. R2 stated staff weighed at and staff checked for y. cord, included diagnoses of and chronic kidney disease and shortness of breath. PS) Minimum Data Set 1/13/2021, identified R2 did mpairment and indicated R2 and diuretic medications. ers included: lema (Start date 12/5/2020) 00 milliliters (ml) per day (start the morning off at bedtime for 12/17/2020) tic) 2.5 milligrams (mg) every ay, Friday for fluid restriction					
	112 3 Humilional Call	e pian, included. Iollow liuld					

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER CALEDONIA REHABILITATION & RETIREMENT (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (AGENCY) B. WING				A. BUILDING: _			
CALEDONIA REHABILITATION & RETIREMENT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (X6) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			00073	B. WING		_	
CALEDONIA REHABILITATION & RETIREMENT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	NAME OF PROVIDE	VIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	ATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CALEDONIA RE	A REHABILITATIO	N & RETIREMENT				
2 830 Continued From page 37 2 830	PRÉFIX (E	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
restriction 2 liters per day, record and monitor intake daily, weigh resident per facility protocol. R2's care plan identified R2 had diagnoses of hypertension and congestive heart failure; associated interventions included monitor for and document any edema notify physician, weight weekly, monitor/document/report as needed any signs/symptoms of congestive heart failure. EDEMA R2's record was reviewed from 2/10/21 to 2/22/21, R2's record did not include consistent edema monitoring and evaluation according to the care plan and physician orders. R2's progress note dated 2/11/2021, at 2:20 p.m. indicated R2 had a hard cast removed and cam boot applied to his right foot, and weight variance may be related to the new device. Breath sounds even and unlabored lung sounds clear. Bilateral lower edema 1+. Tubigrips on both lower extremities and left arm. A subsequent note at 9:17 p.m. indicated at 6:00 p.m. R2 had showed nurse several fluid filled bilster and open wounds on the right leg were the cast was. R2's progress note dated 2/20/21, included " + 3 pitting edema to lower legs and feet bilaterally. Left arm edema present from elbow to fingers. R2's progress note dated 2/21/21, at 2:01 a.m. included "resident coughing 0100 [sic] blood. Listening to lungs wheezing could be heard in his right upper lungs." A subsequent note at 5:50 a.m. included, "Resident die [sic] not cough out anymore bloody phlegm, vitals stable will continue to monitor resident for change of condition and update primary provider.	restrict intake R2's chyper associated week signs. EDEN R2's chyper associate	striction 2 liters parallel stake daily, weigh 2's care plan identification and obsection and unlabored were and unlabored were dema 1+. To the right leg we are plan and obsection and unlabored were dema 1+. To the right leg we 2's progress noted the general fluid of the right leg were also better arm edema processes and observed and the progression of the progression	rer day, record and monitor resident per facility protocol. atified R2 had diagnoses of congestive heart failure; antions included monitor for anoma notify physician, weight cument/report as needed any congestive heart failure. Viewed from 2/10/21 to ad did not include consistent and evaluation according to ohysician orders. dated 2/11/2021, at 2:20 p.m. hard cast removed and cam right foot, and weight variance he new device. Breath sounds at lat 6:00 p.m. R2 had showed filled blister and open wounds are the cast was. dated 2/20/21, included " + wer legs and feet bilaterally. esent from elbow to fingers. dated 2/21/21, at 2:01 a.m. coughing 0100 [sic] blood. wheezing could be heard in hi A subsequent note at 5:50 sident die [sic] not cough out allegm, vitals stable will resident for change of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00073		B. WING			C 2/26/2021
NAME OF I	PROVIDER OR SUPPLIER		REET ADI		STATE, ZIP CODE		2/20/2021
				H BADGER	,		
CALEDO			ALEDON	IIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 38		2 830			
	R2's weight change R2 triggered for we	e note dated 2/21/21, ind ight gains	licated				
		dated 2/21/21, at 8:00 p a bit of wheezing in the					
	weights and indicat same time every da	m 262 pounds lbs. m 265.2 n264.4 n265.2 n264.2 m265.4 m261.8 m266.0 m269.2 m266.4 n266.8	at the				
		evidence of monitoring antake according to physical plan.					
	to 2/22/21, the reco of fluid intake, and a evaluation of 24 ho identify fluid volume Based on the docu determined if R2's 2 followed according On 2/10/21, breakfa	ecord was reviewed from ord lacked consistent received the record lacked evider ur fluid intake in order to expedicate and/or overage mentation it cannot be 2 Liter fluid restriction was to physician orders. ast intake documented a ch and dinner intake was	cording nce of es. as "not				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00073			02/2	; 6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 02/2	0/2021
CAI FDONIA REHABII ITATION & RETIREMENT			TH BADGER NA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	ml. On 2/11/21, breakfalunch 200 ml, and odocumented as "no On 2/12/21, breakfadinner- was left blar On 2/13/21, breakfadinner documented On 2/14/21, breakfadinner documented On 2/15/21, breakfadinner was left blar On 2/16/21, no fluid day On 2/17/21, breakfadinner was left blar On 2/18/21, 240 ml On 2/18/21, breakfaml, dinner was left lon 2/20/21, breakfaml, dinner was left lon 2/20/21, breakfaml, dinner intake won 2/21/21, breakfaml, dinner 180 ml. During an interview registered nurse (R documenting fluid in administration recoin R2's record where documented and st determined how muon a daily basis. RN be a good person to During an interview NA-D stated dietary the computer after the c	ast intake documented as "0", dinner 200 ml, dinner at applicable" ast was 225 ml, lunch 200 ml, nk ast was documented as "not 40 ml, dinner 240 ml, ast was 240 ml, lunch 240 ml, as "not applicable" ast was 120 ml, lunch 120 ml, lk. I intake was recorded for the ast 240 ml, lunch 240 ml, lk. I was recorded for each meal. ast was left blank, lunch 240 blank ast was left blank, both lunch was 240 ml ast was left blank, lunch 120 ml, last was left blank, lunch 120 ml, ast was left blank, lunch 120 ml, ast was left blank, lunch 120 ml, last was left blank, lunch 120 ml, las	2 830			

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A. BUILDING: O0073 NAME OF PROVIDER OR SUPPLIER O0073 A. BUILDING: C C O2/26/202	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			
·				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				
425 NORTH BADGER STREET				
CALEDONIA REHABILITATION & RETIREMENT CALEDONIA, MN 55921	CALEDONIA REHABILITATION			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPANY OF CORRECTION SHOULD BE COMPANY OF COMPANY OF CORRECTION SHOULD BE COM	PREFIX (EACH DEFICIEN			
2 830 NA-J stated she used to work in dietary, NA-J stated dietary staff would record the amount of intake in the computer for each meal, if dietary staff did not have time on their shift, the next shift would record it for them. NA-J stated they did not record any other intake besides what the resident was provided with meals. NA-J indicated an unawareness of who was documenting the amount of fluid intake outside of meals. During an interview on 2/25/2021, at 8:15 a.m. nursing assistant (NA)-I stated she was not sure if R2 was on a fluid restriction or not. NA-I stated NA's did not record fluid intake and that kitchen people tracked that. During an interview on 2/26/2021, at 8:51 a.m. trained medication assistant (TMA)-A stated when she passed medications she did not record the amount of fluid intake and dietary staff tracked fluid intake. During an interview on 2/26/2021, 9:18 a.m. RN-A stated if a resident was on a fluid restriction, the dietician determined how much fluid was divided over each meal, how much the resident could have in his room, and the amount allowed for medication passes. RN-A stated NA's were supposed to communicate to the nurse if the resident was requesting additional fluids outside of what they were provided. RN-A stated "I don't believe that there is someone evaluating the 24 hour totals, our dietician may go in but I can't confirm that." During an interview on 2/25/2021, at 11:22 a.m. director of nursing (DOM) reviewed R2's fluid intakes and stated the facility did not have a solid	NA-J stated she ustated dietary starintake in the computation of the confict of the cord and other in was provided with unawareness of vamount of fluid in the computation of the cord and in			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00073	B. WING		02/2	6/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
L CALEDONIA REHABII ITATION & RETIREMENT			TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 41	2 830			
	evaluation of the incompleted.	takes was not being				
	certified dietary ma and housekeeping if a resident is on fla a sheet of paper. Consupposed to record the computer. CDM who was evaluating CDM stated an una documenting fluid in meals such as fluid during medication president requests. Facility policy Press Breakdown-Clinical included 2. The nurse shall of the following: Full a including location, so depth, presence of Current treatments 3. The staff will exal admission for ulcer	descrbe and docuemtn reprot assessment of pressure sore size, stage, length, width, and exudates or necrotic tissue. i, including support surfaces. imine the skin of a new ations or alterations in skin.				
	managemet were reprovided.	take monitoring/edema equested and were not THOD OF CORRECTION:				
	could review/revise related to falls, acci supervision to assu	or of nursing or designee, policies and procedures idents and resident are proper assessment and eing implemented and the				

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00073 B. WING C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		
00073 B. WING 02/26/202			
NAME OF PROVIDED OR GURDUER			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PRO\		
CALEDONIA REHABILITATION & RETIREMENT 425 NORTH BADGER STREET CALEDONIA, MN 55921	CALEDONIA REHABILITATION & RETIREMENT		
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) X4 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) X5 COMMON PROVIDER'S PLAN OF CORRECTION (COMMON PREFIX TAG) X6 COMMON PROVIDER'S PLAN OF CORRECTION (COMMON PREFIX TAG) X6 COMMON PROVIDER'S PLAN OF CORRECTION (COMMON PREFIX TAG) X7 COMMON PROVIDER'S PLAN OF CORRECTION (COMMON PREFIX TAG) X8 COMMON PROVIDER'S PLAN OF CORRECTION (COMMON PREFIX TAG) X8 COMMON PROVIDER'S PLAN OF CORRECTION (COMMON PREFIX TAG) X8 COMMON PROVIDER'S PLAN OF CORRECTION (COMMON PREFIX TAG) X9 COMMON PROVIDER'S PLAN OF CORRECTION (COMMON PREFIX TAG) X9 COMMON PROVIDER'S PLAN OF CORRECTION (COMMON PREFIX TAG) X9 COMMON PROVIDER'S PLAN OF CORRECTION SHOULD BE COMMON PROVIDER'S PLAN OF CORRECTION (COMMON PREFIX TAG) X9 COMMON PROVIDER'S PLAN OF CORRECTION SHOULD BE COMMON PROVIDER'S PLAN OF CORRECTION	PREFIX		
provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. PRESSURE ULCERS: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcers (to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. DIALYSIS: DON/designee could review/revise facility policies/procedures, and provide re-education to nursing staff for coordination of care with the dialysis clinic. In addition, the facility could develop and implement a system for recording/monitoring/and evaluation fluid intake. The facility could then develop and implement an auditing system as part of the quality assurance activities to maintain compliance. FLUID MANAGEMENT: DON/designee could develop policies/guidelines monitoring and evaluating fluid balance. The DON/designee could then provide education to nursing staff, and develop and auditing system as part of the quality assurance activities to ensure ongoing compliance. IMPAIRED SKIN INTEGRITY: DON/designee could review polices/protocols for admission skin	procoor po and the rest factor of the present of th		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		00073	B. WING			26/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 43	2 830			
	re-educate nursing implement an audit quality assurance a compliance.	designee could then staff. The facility could then ing system as part of their activities to maintain				
21375	. , .	0 Subp. 1 Infection Control;	21375			4/14/21
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observatireview, the facility for Disease Control (Cond/or minimize the by ensuring staff ut protective equipme including the use of care to residents not the facility during the 3 residents (R 138, addition, the facility admission presume quarantined in their residents (R139) we resident council meto ensure proper in administering medi	ent is not met as evidenced ion, interview and document ailed to follow the Centers for DC) guidelines to prevent e transmission of COVID-19 ilized appropriate personal nt (PPE) precautions, f gowns, when providing direct ewly admitted/re-admitted to neir 14-day quarantine for 3 of R139, R137) observed. in failed to ensure new ed positive residents were room for 14-days for 1 of 1 ho attended the group eeting. The facility also failed fection control technique while cation for 1 of 7 residents ing medication administration.		Corrected.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
		00073	B. WING			6/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDONIA REHABILITATION & RETIREMENT			TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	Continued From pa	age 44	21375			
	Findings include:					
	to facility on 2/12/2	identified an admission date 021, with diagnoses that e sleep apnea and ventral ne.				
	during R138's hosp treatment was start pneumonia. The su discharge from the have expiratory wh X-ray showed persi	charge summary, indicated oital course he developed and ted for ventilator associated ummary indicated upon hospital R138 was "noted to eezes to auscultation.", chest istent bilateral airspace e progression in the left lower umonia.				
	During an observation on 2/22/2021, at 3:07 p.m. R138's room did not have signage or personal protective equipment (PPE) outside of his room that would identify R138's required transmission based precautions. R138 was observed to be sitting in his recliner in his room.					
	R138 sat in his recl he was going to cal coughed (dry non-p mouth). Nursing as R138; NA-E wore a but did not have a redirect R138 from	tion on 2/22/2021, at 4:10 p.m. liner in his room. R138 stated Il 911 for his cough. R138 productive, covered his esistant (NA)-E stood next to a face mask and eyes shield gown on. NA-E attempted to calling 911. NA-E washed and s before she exited R138's				
	2/22/2021, at 4:15 entered R138's roo	tion and interview on p.m. registered nurse (RN)-A om with a face shield and a not have a gown on. RN-A				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
		00073	B. WING			6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21375	Continued From pa	ige 45	21375			
	hospital and had be respiratory illness r had a dry cough int RN-A indicated R13 new hospital admis	I been admitted from the een treated in the hospital for not related to COVID-19 and termittently since admission. 38 was quarantined related to sion, confirmed there was not taide of R138's room.				
	to facility of 2/20/21	identified an admission date with diagnoses including ic obstructive pulmonary				
	2/19/2021, indicate Covid-19 on 2/19/2	charge summary dated d R139's tested negative for 021. The summary did not was tested for COVID-19.				
	2/22/2021, at 3:30 signage or PPE outhis bed. R139 state to the facility a couphad informed him had arantined for a wout of his room to g	cion and interview on p.m. R139's room did not have tside of his room. R139 sat in ed he had just been admitted ple of days ago; facility staff he was supposed to be while and had been only been jet weighed. R139 was not espiratory symptoms.				
	RN-A and director R139's room; both shield however did changed R139's gr	ion on 2/23/2021, at 8:52 a.m. of nursing (DON) were in wore a face mask and face not have a gown on. RN-A oin dressing. R139 was not espiratory symptoms.				
	R137					
	R137's face sheet,	identified an admission date				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			:
		00073	B. WING			6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALEDONIA REHABILITATION & RETIREMENT			TH BADGER NA, MN 559			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	, -	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
21375	Continued From pa	ige 46	21375			
		with diagnoses including e and avoidant personality				
	2/22/2021, at 4:27 signage or PPE our she had been admit	ion and interview on p.m. R137's room did not have tside of her room. R137 stated itted to the facility almost two was not observed to have ms.				
	During an interview on 2/23/2021, at 4:06 p.m. NA-H indicated that the one hallway was where the facility put residents who came from the hospital and those residents were on quarantine, (R137, R138, and R139). NA-H stated we have not ever been required to wear gowns for hospital admissions, only masks and face shields. NA-H confirmed that there was no signage or PPE stations down that hallway or in front of the residents rooms, and if you were not an employee of the facility you would have to ask the nurse to find out if there were any special precautions. NA-H stated R137 and R139 have not had any symptoms, and R138 had been admitted with a dry cough that would come and go; stated it was something else besides COVID-19.					
	licensed practical n there was not PPE the resident's room related to hospital a	on 2/23/2021, at 4:11 p.m. nurse (LPN)-B confirmed that stations or signage in front of s that were on quarantine admissions. LPN- indicated if of concern, then gowns				
		on 2/23/21, at 3:15 p.m. the (DON) confirmed all residents				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
		00073	B. WING		02/2	, 6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDONIA REHABILITATION & RETIREMENT			TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	into the facility need are quarantined to stated at the last fautilizing full PPE wheresident on quarant facility staff had not entering quarantine unsure how many gracility. When interviewed confirmed the facility storage and would precautions including immediately for the residents. The policy titled CC indicated: Persons suspected covid in precautionary measure be handled as follow precautions, contact protection, and a medication and medication and medication and medication and medication used to milligrams (mg) given interest at the last facility and the state of	r re-admitted from the hospital d a negative Covid-19 test and their room for 14 days. DON cility she worked at the staff nen entering the room of a tine and confirmed at this to been utilizing gowns when ed resident rooms. DON was gowns were on hand at the con 2/23/21, at 4:36 p.m. DON ty had 8 cases of gowns in be initiating dropleting the use of gowns new and re-admitted consumer of the standard consumer of the sta	21375			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
71101 1211	OF COUNTED HOW	BENTI TOXITON NOMBER.	A. BUILDING:			
		00073	B. WING		02/2	6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT 425 NOF	TH BADGER	STREET		
OALLDC	MARCHABIENATION	CALEDO	NIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	age 48	21375			
21375	mouth two times a anticonvulsant med nerve pain) 100 mg two times a day, may by mouth in the moone tablet by mouth paroxetine HCI (an 20 mg give 40 mg to 20 mg give 40 mg to 20 magnesium oxide 4 tablets, Tegretol 20 magnesium oxide 4 tablet. After dishing TMA-A obtained a package (a packing pre-formed plastic a folds together to for one of the tablets of handed the package The medication was tablet by mouth thresticker on it that real brought to TMA-B's already dished up and that this was the removed the Tegret cup with her bare he medication back into the nobtained a diff package and pushed blister package into handed the package The medication was three times a day. TMA-B that she had	day, gabapentin (an dication also used to treat give 2 capsules by mouth agnesium oxide give 400 mg orning, multiple vitamin give in the morning, and antidepressant medication aide rived setting up medications for order: gabapentin 100 mg, 400 mg, fish oil 1000 mg, 400 mg, and multiple vitamin, medication in a blister graph design consisting of attached to a backing or that rim a seal). TMA-B pushed but of the blister package, then ge to the surveyor to review. The sattention that she had allowed and the second and the second and the surveyor to review attention that she had allowed and the second and the second and the surveyor to review and the second and the surveyor to review. The second and the se				
	paroxetine HCI (an 20 mg give 40 mg kl 20 magnesium oxide 4 tablets, Tegretol 20 magnesium oxide 4 tablet. After dishing TMA-A obtained a package (a packing pre-formed plastic a folds together to for one of the tablets of handed the package. The medication was tablet by mouth thresticker on it that real brought to TMA-B's already dished up from the analytic and that this was the removed the Tegret cup with her bare him medication back into the nobtained a difficult package and pushed blister package into handed the package. The medication was three times a day. TMA-B that she has medication. TMA-E	antidepressant medication) by mouth in the morning. B a.m. trained medication aide rved setting up medications for gorder: gabapentin 100 mg, 400 mg, fish oil 1000 mg, 400 mg, and multiple vitamin, medication in a blister graph design consisting of attached to a backing or that rm a seal). TMA-B pushed but of the blister package, then ge to the surveyor to review. The sattention that she had represent the surveyor seattention that she had represent the surveyor to review attention that she had represent from the medication ands, then replaced the to the blister package. TMA-A ferent medication blister red one of the tablets out of the pet to the surveyor to review. The sattention that she had represent medication blister red one of the tablets out of the pet to the surveyor to review. The sattention of the surveyor pointed out to				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00073		B. WING			C 26/2021
	PROVIDER OR SUPPLIER	I & RETIREMENT	425 NOR1	DRESS, CITY, S FH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	hands, then replace the blister package When interviewed of TMA-B confirmed it tape medications be punched out by mis confirmed it was ok remove the medical utilized the hand satisfied the hand satisfie	ed the medication backed the medication backed into the blister parack into see her bare hand tions from the med continuitizer so much that into 2/24/21, at 1:20 p. (DON) stated she work in the search a medication if ster package in error, the blister package with their bare in control concern. It is start a medication with their bare in control concern. It is start a medication in the search in control process, etc.) when these are soft medications. CIL MEETING identified an admission with diagnoses inclusion obstructive pulmon of the survey on 2/23/2 as a new admission that we been on 14 day in a survey been on 14 day in a survey been on 14 day in a survey on 2/23/2 as a new admission that we been on 14 day	i.m. Inctice to lack if Ids t	21375			

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Minnesota Department of Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00070	B. WING		00/0	
		00073	D. WINO		02/2	6/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	I & RETIREMENT	TH BADGER NA, MN 559			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 50	21375			
	director of nursing (gave her the names attended the reside immediately said R as he was a new ac positive and was or every new admissic presumed positive the 400 hall was the DON stated the act R139 was on a quadefense we did not indicate the resider quarantine. The DO residents were to so During an interview AD stated there was between her and act The AD stated there was between her and act The AD stated she participate in the rebecause he was on was fine as she tho completed in individing the DON (Director review/revise facility contain all componer program, including required and quarar returns and new add positive upon admis verify staff training and CMS guideline risks for COVID-19	of Nursing) or designee could y policies to ensure they ents of an infection control personal protective equipment ntine practices for hospital mission who are presumed ession to the facility, and could and implementation of CDC are implemented to reduce. Then the DON or designee ne audits to ensure the				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
,	0. 0020	.5	A. BUILDING:			
		00073	B. WING		02/2	26/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 51	21375			
	Time Period for Co	rrection: One (1) day.				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			4/14/21
	maintain a comprel infection control pro current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement (b) Written complia be maintained by the This MN Requirement by: Based on interview facility failed to ensfor tuberculosis (TE Center for Disease (CDC) recommend	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines of States Centers for Disease of States Centers (MMWR). Include a tuberculosis on that covers all paid and contractors, students, onteers. The Department of the technical assistance of the entation of the guidelines. Include a tuberculosis of the Department of the technical assistance of the technical assistance of the guidelines. Include a tuberculosis of the technical assistance of the technical assistance of the guidelines. Include a tuberculosis of the technical assistance of the guidelines. In the department of the technical of the potential of the pote		Corrected.		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
7110117111	or continue	IDENTIFICATION NOMBER.	A. BUILDING:			
		00073	B. WING		02/2	26/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CALEDO	NIA REHABILITATIOI	N & RETIREMENT	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	Continued From pa	age 52	21426			
	When interview on 2/26/21, at approximately 3:25 p.m. the director of nursing confirmed the facility had no evidence a current TB facility risk assessment had been completed.					
	Policies related to TB were requested but not received.					
SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could review policy and procedure and develop a schedule to complete the required assessment.						
	TIME PERIOD FOI Twenty-one (21) da					
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			4/14/21
	monitor each reside unnecessary drug in home's policies and pharmacist must resident's attending physician does not home's recomment adequate justification believes the reside adversely affected, matter to the medical director attending physician justification for the physician does not must be referred for Assurance and A	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If or determines that the nodes not have adequate order and if the attending change the order, the matter or review to the Quality sessment (QAA) committee 58.0070. If the attending				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED		
				B. WING		C 02/26/2021	
		00073		B. WINO		02/2	6/2021
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
CAI FDONIA REHABII ITATION & RETIREMENT				TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Continued From page 53			21540			
		dical director, the co fer the matter directl					
	by: Based on interview facility failed to com assessment to deteordered for insomn	ent is not met as event and document revieus plete a comprehense rmine the need for site for 1 of 5 residents essary medications.	ew the sive sleep sleep aids		Corrected.		
	Findings include:						
	R12's admission record revealed R12 was admitted on 9/27/20 with diagnoses of dementia with behavioral disturbance, anxiety and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 11-30-20, indicated R12 did not display behavior problems or difficulty sleeping, feeling tired or having little energy.						
	MG (milligrams) Giv	ders included Trazod ve 1 tablet by mouth ia/restlessness. The 0/29/2018.	at				
	R12's care plan did non-pharmacologic	not include al interventions for s	sleep.				
	comprehensive slee	rd lacked evidence of ep assessment and for continued use of	analysis				
		t progress note date The patient is a plea					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7	o. oo.u.20o	.5	A. BUILDING:			
		00073	B. WING		02/2	; 6/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
CALEDO	NIA REHABILITATION	N & RETIREMENT	TH BADGER NA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 54	21540			
		i, I am seeing for a routine visit n, appetite or sleep problems				
	director of nursing (to locate sleep mor for R12. The DON	on 2/25/21, at 9:03 a.m. the (DON) stated she was unable nitoring or a sleep assessment verified a sleep assessment nelp determine justification for e medication.				
	During an interview on 2/02/25/21, at 5:17 p.m. registered nurse (RN)-A stated sleep assessments would be documented under assessments and if was unable to find one there, would assume a sleep assessment had not been done. RN-A stated sleep assessments should be completed quarterly, annually, with a change of condition and change of sleep.					
	A policy and proced was requested and	dure for sleep assessments not provided.				
	SUGGESTED MET	HOD OF CORRECTION:				
	assure that policies and that staff training assure resident's re- insomnia have slee	sing and or designee could and procedures are updated ing has been completed to eceiving medications for in monitored and sleep eleted to ensure residents are sary drugs.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-One				
21910	MN St. Statute 144 Residents of HC Fa	.651 Subd. 25 Patients & ac.Bill of Rights	21910			4/14/21

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				7 50.2510.		С	
	00073			B. WING		02/2	6/2021
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
CALEDO	CALEDONIA REHABILITATION & RETIREMENT			TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21910	Continued From page 55			21910			
	residents may man affairs, or shall be g accounting of finan- behalf if they delega	ial affairs. Compete age their personal figiven at least a quarcial transactions on ate this responsibility a laws of Minnesotal of time.	nancial terly their y in				
	This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to keep an accounting of money in the resident funds accounts and failed to keep any resident fund money in an interest-bearing account. This had the potential to affect all 12 residents that had money in a personal fund account with the facility.			Corrected.			
	Findings include:	on 02/25/21 at 12:	25 n m				
	the administrator ar (BOM) stated 12 cu accounts and the fa at this time how mu resident account. T planning to go to th to figure out how m account from the badeposits. The BOM were kept in a check saving account. The going to work with hinto an interest-beat talked to the bank as	on 02/25/21, at 12:2nd business office murrent resident had tracility was unable to uch money was in each e BOM stated she e bank to get the de uch money was in each documentation of stated the resident exing account rather to get money training account and stated that this afternation of the stated the baner to get money training account and stated that this afternation of the stated that the state	anager rust determine ich was posit slips ach of funds than a ank was insferred ated she oon.				
	A policy on personal requested and not p	al funds accounts wa provided.	as				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
				B 14/10/0	P. WING		С	
		00073		B. WING		02/2	6/2021	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CALEDO	NIA REHABILITATION	N & RETIREMENT		TH BADGER NA, MN 559				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
21910	Continued From page 56			21910				
	State Bill of Rights resident representate the last revision on "Self-Determination facility must deposifunds in excess of account (or account of the facility's oper credits all interest ethat account. (In possible as a separate accountb. Residents who Medicaid: The facility personal funds in einterest-bearing accounts, and that resident's funds to accounts, there must for each resident's SUGGESTED MET The Administrator of are maintained by the \$100.00 and \$50.00 an interest bearing randomly audit accounts.	count (or accounts) to of the facility's operatoredits all interest ea that account. (In poost be a separate acc	ts and on]" with nder sa. The onal earing rom any that funds to must be 's share.) residents' hat is ting urned on led ounting TION: ds that of enst are in ould pliance.					
21942	MN St. Statute 144 Resident and Fami	A.10 Subd. 8b Estab ly Councils	lish	21942			4/14/21	
	boarding care home advisory council an	council. Each nursing e shall establish a re d a family council, ur ersons express an int	sident nless					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP			SURVEY LETED		
		00073		B. WING		02/2	6/2021
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CALEDO	NIA REHABILITATION	& RETIREMENT		H BADGER			
	0.18444524074	TEMENT OF REFIGIENCIE		NIA, MN 559		011	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21942	Continued From page 57			21942			
	function, the nursing home shall docume council or councils year. This subdivisi	or both councils do g home or boarding ent its attempts to estat least once each con does not alter the les provided by section 27.	care tablish the alendar e rights of				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council during the past calendar year.			Corrected.			
	Findings include:						
	During an interview on 2/24/21, at 12:41 p.m. the director of nursing (DON) stated the facility did not have an active family council. The DON verified there had been no documented attempts by the facility to establish a family council during the past year.						
		olicy and Procedure provided by the facili					
	The administrator of individual to be respattempt to establish individual would need	THOD OF CORRECT designee could desponsible for the annual a family council/growed to document it's earnd identify when the endar year.	legate an ual up. That efforts at				
	TIME PERIOD OF (21) days.	CORRECTION: Twe	enty-one				

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

PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE LUTHERAN HOME CALEDONIA			(X3) DATE SURVEY COMPLETED	
		245499	B. WING			02/2	24/2021
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET CALEDONIA, MN 55921		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs .	ΚO	000			
	FIRE SAFETY						
	Minnesota Departm Fire Marshal Division Caledonia Care and in compliance with the participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA) Code (LSC), Chapte THE FACILITY'S Po	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, d Rehab Center was found not the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety er 19 Existing Health Care. OC WILL SERVE AS YOUR COMPLIANCE UPON THE					
	DEPARTMENT'S A SIGNATURE AT TH	CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS					
	ON-SITE REVISIT CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY					
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION).					
	Health Care Fire In	•					
I ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(X6) DATE

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

TITLE

Electronically Signed

03/23/2021

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

PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE LUTHERAN HOME CALEDONIA			(X3) DATE SURVEY COMPLETED				
		245499	B. WING	B. WING			02/24/2021		
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 25 NORTH BADGER STREET CALEDONIA, MN 55921	, , ,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
K 000	State Fire Marshal 445 Minnesota St., St Paul, MN 55101. By email to: fm.hc.Inspections@ THE PLAN OF COLDEFICIENCY MUSFOLLOWING INFO. 1. A description of vto correct the deficition of vto correct the deficition. 2. The actual, or provide a reoccurred a reoccurred a reoccurred Caledonia Care and The building was determined to with a full basement. In 1971, addition was determined to be of with no basement. In 1975, addition was determined to be of with no basement. In 1975, additions construction and mallowed for existing surveyed as one buinto four separate so the building is protection.	Division Suite 145 -5145, or State.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. d Rehab is a 1-story building. onstructed at 3 different times. g was constructed in 1961 and be of Type II(000)construction,		000					

PRINTED: 04/23/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - THE LUTHERAN HOME CALEDONIA 245499 B. WING 02/24/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **425 NORTH BADGER STREET CALEDONIA REHABILITATION & RETIREMENT CENTER** CALEDONIA, MN 55921 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 000 | Continued From page 2 K 000 full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 38 at the time of the survey The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress - General K 211 4/14/21 SS=F 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 Adjustments were made to the doorframe facility failed to maintain proper means of egress by maintenance director filing down a requirements in accordance with the Life Safety portion of the frame and the door no Code NFPA 101 - 2012 edition, sections 7.2.1.4.1 longer requires 30lbs of force to open. and 7.2.1.7. This deficient practice could affect The door was tested and meets the all 49 residents. requirement compliantly. Monitoring of this deficiency to mitigate future citation includes education to the Findings include: Maintenance Director of regulation on On facility tour at 10:00 AM on 02/24/2021, door pressure, adding the task of door observations and staff interview revealed the force to standard building rounds, and following: 1x/month audit for 12 months on door force. Finds to be reviewed at QAPI for During walk-through of the facility observed on audit continuation. the 1st Floor that more than 30 pounds of force Corrective action completed by 4/14/21

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		245499	B. WING	B. WING			02/24/2021	
	PROVIDER OR SUPPLIER	N & RETIREMENT CENTER		425 N	ET ADDRESS, CITY, STATE, ZIP CODE IORTH BADGER STREET EDONIA, MN 55921		-	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE	
K 923	During walk-through the 1st Floor the Mo storage of O2 cylind This deficient pract	h of the facility observed on ed Gas Room had mixed ders (empty/full) ice was confirmed by the e Director and Administrator at	KS	C M	Forrective action completed by 4/1 laintenance/Designee is responsite orrection and ongoing compliance	ble for		