Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 2, 2024

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: February 29, 2024

Dear Administrator:

On March 13, 2024, we notified you a remedy was imposed. On March 27, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 22, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 28, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 13, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 28, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 22, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 2, 2024

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

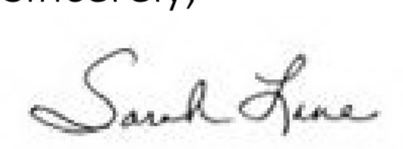
Re: Reinspection Results
Event ID: ERF012

Dear Administrator:

On March 27, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 29, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 13, 2024

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: February 29, 2024

Dear Administrator:

On February 29, 2024, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 28, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 28, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 28, 2024.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 28, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Neilson Place will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 28, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 29, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

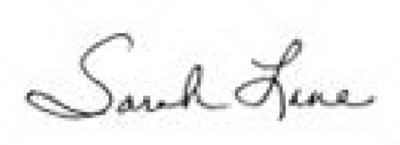
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

Feel free to contact me if you have questions.

Sincerely,



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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 13, 2024

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

Re: State Nursing Home Licensing Orders
Event ID: ERF011

Dear Administrator:

The above facility was surveyed on February 27, 2024 through February 29, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

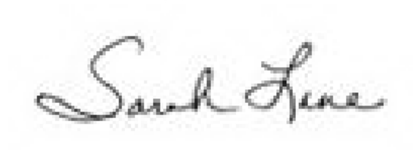
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

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

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

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245039	A. BUILDING _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEILSON PLACE	1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/27/24 through 2/29/24 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints was reviewed: H50391140C (MN100954) with a deficiency cited at F686. H50391161C (MN100611) with a deficiency cited at F689. H50391188C (MN100026) H50391187C (MN100613, MN99254) with a deficiency cited at F689. As a result of the survey additional deficiencies were cited at F609, F610, F585. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 585 SS=D	. Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or	F 585		3/22/24

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

Electronically Signed | 03/19/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 585	Continued From page 1 reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency,	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 585	Continued From page 2 Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 585	Continued From page 3 or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to operationalize their policy for prompt resolution of grievances for 1 of 1 residents (R3) reviewed who filed a grievance related to care concerns in the facility. Findings include: R3's Physician Orders dated January 2024, were reviewed. The orders did not include an order for Nitroglycerine tablets. A facility document titled Healthcare Safety Zone dated 2/1/24, indicated R3's family member (FM)-A spoke about a medication (Nitroglycerine) they received a bill for. FM-A stated R3 did not have an order for the medication and said R3 told her the medication was in her medication cupboard and a nurse had tried to give her the medication but R3 had refused. FM-A further identified concerns related to supplies and a skin issue and the nurse on duty, when the skin issue was identified, stated she did not have time to look at. During interview on 2/29/24 at 11:08 a.m., FM-A stated the facility had not followed up with her about concerns as she had requested.	F 585	The following disclaimer should be written in the “Provider’s Plan of Correction” column prior to responding to the first survey citation: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center’s allegation of compliance in accordance with section 7305 of the State Operations Manual. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? • On 2/29/2024 R4’s complaint was reviewed and addressed by nursing leadership. Follow-up was provided to R4’s family members regarding the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 585	Continued From page 4 During interview on 2/29/24 at 11:42 a.m., licensed social worker (LSW)-A stated the grievance was routed to the nurse manager, registered nurse (RN)-A for follow up because the concerns were clinical in nature. During interview on 2/29/24 at 12:45 p.m., RN-A stated she had looked into the concerns but did not have any supporting documentation. RN-A stated she was just putting the information into the follow up section of the grievance form today. During interview on 2/29/24 at 12:59 p.m., the administrator stated she thought RN-A was going to follow up with FM-A. The administrator stated she should have reviewed the grievance to ensure follow up. Facility Policy Resident Grievances dated 6/6/23, indicated a resident has the right to voice grievance to the facility or other agency. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished. A written grievance or an oral grievance which the resident or resident representative states he/she wishes to be handled as a written grievance will be written and responded to in writing within seven days of receipt.	F 585	medication, supplies, and skin issues. Facility will assume financial liability for medication. A written response to grievance was sent on 3/19/2024. How will other residents, having the potential to be affected by the same deficient practice, be identified? • All residents in the facility have the potential to be affected by the deficient practice. Therefore, all open grievances will be reviewed by social services by 3/22/2024 to ensure closed loop communication on the concerns. Follow up has been provided and ensure actions are resolved. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? • To ensure systemic changes are sustained, the facilities policy Resident Grievances was reviewed by Administrator and Social Services Manager on 3/11/2024. The facility will review all grievances weekly at the IDT meeting to ensure issues are being addressed timely and follow-up is being provided. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? • The social worker or designee will audit all grievances weekly for 6 weeks to ensure issues are being addressed timely and follow-up is being completed. The results of these audits will be reported to the QAPI committee for review and	

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F 585	Continued From page 5	F 585	recommendations. The QAPI committee will determine if further auditing needs are necessary. What is the date of completion? • 3/22/2024	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		3/22/24

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F 609	Continued From page 6 Based on interview and document review the facility failed to report a fall from a mechanical stand that resulted in a broken clavicle (collarbone) to the state agency (SA) for 1 of 3 residents (R2) reviewed for falls. Findings include: R2's care plan dated 1/26/24, identified a risk for falls and directed staff to offer assistance with activities of daily living and transfers. R2's Progress Note dated 2/5/24, indicated staff was assisting R2 to the bathroom using a mechanical stand. R2 let go of the handles and began to slide out of the stand. Staff was able to help guide R2 to the floor. R2 complained of right shoulder pain. R2 agreed to go to the emergency department after dialysis. During interview on 2/27/24 at 3:08 p.m., the director of nursing (DON) stated R2 sustained a skin tear and a broken clavicle. The DON stated the incident was not reported to the SA because staff had identified a decline in condition that contributed to his falls. During interview on 2/27/24 at approximately 3:30 p.m., the administrator stated R2's fall from the lift was not reported to the SA because staff assisted R2 during the fall. During interview on 2/28/24 at 12:36 p.m., the facilities EZ- Lift representative stated if a fall occurred from a mechanical stand it could have been the straps were not properly attached. The representative said if the harness was still attached, likely the resident was not properly situated in the sling. The representative stated a	F 609	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? • All staff members involved in the incident will be educated by the Administrator or designee on the facilities abuse and neglect policy by 3/22/2024. How will other residents, having the potential to be affected by the same deficient practice, be identified? • All residents in the facility have potential to be affected by this practice. As a result, all nursing staff have been educated on our abuse and neglect policy by 3/22/2024. By 3/22/2024, all falls will be reviewed to ensure that proper investigation and reporting occurs. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? • To ensure systemic changes are sustained, by 3/22/2024 all nursing staff received education per the facility's abuse and neglect policy on reporting vulnerable adult incidents per guidelines. The policy was reviewed on 3/18/2024. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? • All reports of suspected abuse and neglect will be reviewed by administrator or designee during the weekly interdisciplinary team meetings, for the next 6 weeks, or until substantial	

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F 609	Continued From page 7 resident should never slide out of the harness if it was the correct size and attached properly to the lift and the patient. In regard to the mechanical lift slings, the representative stated the slings should be used the way they were designed and said if they were not applied properly or not the correct size it could cause accidents. Facility policy Fall Prevention And Management dated 3/29/23, indicated if the fall involves a medical device secure the device and any parts or accessories for follow up investigation and report to the administrator. Report to the state regulatory agency when appropriate. A policy related to reporting to the SA was requested but not received.	F 609	compliance can be determined. Results will be reported to the QAPI committee for further recommendations. What is the date of completion? 3/22/2024	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		3/22/24

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F 610	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to investigate a fall from a mechanical stand that resulted in a broken clavicle (collarbone) for 1 of 3 residents (R2) reviewed for falls. Findings include: R2's care plan dated 1/26/24, identified a risk for falls and directed staff to offer assistance with activities of daily living and transfers. R2's Progress Note dated 2/5/24, indicated staff was assisting R2 to the bathroom using a mechanical stand. R2 let go of the handles and began to slide out of the stand. Staff was able to help guide R2 to the floor. R2 complained of right shoulder pain. R2 agreed to go to the emergency department after dialysis. During interview on 2/27/24 at 3:08 p.m., the director of nursing (DON) stated R2 sustained a skin tear and a broken clavicle when he fell from the mechanical stand. The DON stated the fall had not been investigated. During interview on 2/27/24 at approximately 3:30 p.m., the administrator stated a formal investigation into the fall had not been completed. During interview on 2/27/24 at approximately 3:45 p.m., licensed practical nurse (LPN)-A stated she had been transferring R2 with the mechanical stand when he fell. LPN-A said R2 had been having a hard time transferring so she used the mechanical stand to bring him to the bathroom. LPN-A said R2 lifted his arms and fell through the	F 610	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? o Facility fully investigated all R2's falls including the fall from a mechanical lift. Resident's care plan interventions were put in place to address resident's fall history. Training will be provided to all nursing staff regarding facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy and on location's internal vulnerable adult investigation checklist. How will other residents, having the potential to be affected by the same deficient practice, be identified? o All residents have a potential to be affected by this practice. All nursing staff will receive education by 3/22/2024, regarding facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and on location's internal vulnerable adult investigation checklist. IDT reviewed all open resident incidents to ensure investigations were completed thoroughly by 3/22/2024. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? o To ensure systemic changes are sustained, education was completed with nursing staff regarding facility's abuse and neglect policy by 3/22/2024. All vulnerable adult checklists and investigations will be	

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F 610	Continued From page 9 lift. LPN-A said the harness was secured around R2 but said it may have loosened when he stood up. LPN-A further stated R2's feet were on the platform but the calf straps had not been secured. LPN-A stated she had not been questioned by the facility following the fall. Facility policy related to thorough investigation of and incident was requested but not received.	F 610	reviewed at the location's interdisciplinary team meeting weekly. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? • All potential vulnerable adult incidents, for the next 6 weeks or until substantial compliance can be determined, will be reviewed by the Administrator or designee to ensure a proper investigation and documentation of investigation did occur. Results of the audit will be reported to the QAPI committee. What is the date of completion? • 3/22/2024	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed monitor and develop and	F 686	What corrective action will be accomplished for those residents found to	3/22/24

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F 686	Continued From page 10 implement interventions to reduce the risk of pressure ulcers for 2 of 3 residents (R1,R4) reviewed. This resulted in actual harm to R1 who developed new and worsening pressure ulcers. Findings include: R1 Admission Observation dated 1/2/24, identified bruises and pressure sores. The observation did not identify location, size or stage of pressure sores. R1's Skin Risk Assessment dated 1/2/24 indicated a Braden Scale for predicting pressure ulcer risk identifed a score of 13, inidcating he was at moderate risk for skin breakdown. R1's Physician Order Report dated 1/2/24 through 2/29/24, identified an order dated 1/2/24, that indicated: weekly skin check. Special instructions: Use wound management module to document wounds/ulcers. R1's Admission Minimum Data Set (MDS) dated 1/8/24, identified intact cognition and indicated he did not display rejection of care behaviors. The MDS indicated R1 had upper and lower extremity impairments and required substantial/maximal assistance with toileting, had an indwelling catheter and was continent of bowel. R1's pressure ulcer care plan created 2/19/24, indicated R4 had deep tissue injuries, pressure ulcers, and areas of maceration. the care plan directed staff to turn and reposition every two hours, perform wound observations as ordered and as needed, assess the pressure ulcer for location, stage, size (length, width,and depth), presence/absence of granulation tissue and epithelia at least weekly or as ordered and avoid	F 686	have been affected by the deficient practice? o On 2/19/2024 R2 Care plan was created to identify his risk for pressure injuries and indicated his current skin concerns along with interventions to help prevent new pressure injuries developing or current pressure injuries from worsening. On 2/29/2024 reviewed R4 care plan which was found to be appropriate. Education was provided to staff on options for repositioning and offloading to ensure care plan of repositioning is followed. How will other residents, having the potential to be affected by the same deficient practice, be identified? o By 3/22/2024 the Director of Nursing/Designee will review all current residents at risk to ensure the facility has completed an individualized comprehensive assessment, reassessment, and consistent monitoring of pressure ulcers to prevent the development and the worsening of pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. Director of Nursing/Designee will educate all nursing staff on the importance of timely repositioning according to residents plan of care. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? o To ensure systemic changes are sustained, the Director of Nursing/designee will review facility	

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F 686	Continued From page 11 friction and shearing forces during transfers or position changes. R1's Progress Notes identified the following: 1/2/24, indicated R1 had a stage II (arterial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough [type of nonviable tissue that occurs as a byproduct of the inflammatory process] or bruising) pressure sore to his coccyx that measured approximately 1 centimeter (cm) x 0.4 cm, wound bed red with minimal slough noted, surrounding skin had bleachable redness, R1 to be turned every two hours or as needed, heels were boggy and had blanchable redness. A correlating Wound Management Report identified a stage II pressure ulcer on R1's coccyx measuring 1 cm x .4 cm with a light amount of exudates. Tissue type indicated slough. 1/11/24, Wound on coccyx is covered with Mepilex. Nurse did not get measurements of wound. Wound has Sanguineous drainage (refers to the leakage of fresh blood produced by an open wound) absent edema and redness. The note lacked evidence a skin assessment was completed. 1/22/24, New Mepilex placed to coccyx and heels. The note lacked evidence a skin assessment was completed. 1/30/24, R1 continued with wound on coccyx, new Mepilex dressing applied to both coccyx and heels. The note lacked evidence a skin assessment was completed. 2/16/24. indicated R1's skin was assessed with	F 686	policies to ensure they include comprehensive skin assessment, reassessment, and ongoing monitoring of pressure ulcers to prevent the development and the worsening of pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. Director of Nursing/designee will educate all nursing staff on the facilities policies regarding comprehensive skin assessment, reassessment, and ongoing monitoring of pressure ulcers. Director of Nursing/Designee will educate all nursing staff on the importance of timely repositioning according to residents plan of care. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? o The Director of Nursing/designee will audit three resident charts with pressure ulcers weekly for 6 weeks. The chart audit will consist of reviewing resident's comprehensive assessment, reassessment, and continued monitoring of pressure ulcers to prevent the development and the worsening of pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. Director of Nursing/designee will audit 6 residents weekly, for 6 weeks, ensuring residents are being repositioned per their care plan. Results will be forwarded to QAPI for further recommendation. What is the date of completion? o 3/22/2024	

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F 686	Continued From page 12 physician and hospice nurse. R1 had a deep tissue injury (pressure ulcer in which area of skin may look purple or dark red, or there may be a blood-filled blister) to right calf that measure 9.5 cm x 0.5 cm, right heel had a non-stageable ulcer (full-thickness pressure injuries in which the base is obscured by slough and/or eschar) that measured 4.5 cm x 3 cm, left calf had a deep tissue injury that measured 6 cm x 1 cm, deep tissue injury to left ankle measuring 3.5 cm x 0.5 cm, left heel had a non-stageable wound that measured 2.5 cm x 3 cm, right shin had a deep tissue injury measuring 5.5 cm x 1.2 cm, stage II pressure ulcer noted to left side of back measuring 1.5 cm x 1.8 cm, coccyx has non-blanchable redness/maceration, two open areas to coccyx that measured 1.5 cm x 0.7 cm with a depth of 0.2 cm, non-blanchable area to right gluteal cleft 1 cm x 1 cm. Each area cleansed with normal saline, Mepilex dressing applied to both heels, both calves, and on back, protective barrier applied to coccyx. physician ordered to wash resident up twice daily, change shirt daily, reposition-side to side every two hours and as needed. Correlating Wound Management Detail Reports dated 2/16/24, identified wounds to R1's left heel, right and left calves and coccyx. 2/22/24, Written by registered nurse (RN)-B Resident had a bed bath this morning, given by hospice nurse. Wounds were measured and Mepilex placed on his heels, back and right shin,. The other areas were left open to air. The areas measured as follows: Right calf 9.5 cm x 0.5 cm, right heel 4.5 cm x 4 cm, left calf 6 cm x 0.8, left ankle 3 cm x 0.5 cm, left heel 2 cm x 3 cm, right shin 5.4 cm x 1.2 cm , back 1 cm x 0.8 cm, coccyx scattered small openings, right gluteal cleft 0.8 cm x 0.7 cm. Other areas of his body are	F 686		

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F 686	Continued From page 13 clear, no other open areas. Resident did not tolerate the treatment well, it was very painful. 2/22/24, written by RN-B, this nurse called hospice nurse to find out more extensive information about the wounds on this resident and her findings. Wound Management section charted. Correlating Wound Management Detail Reports dated 2/22/24, identified wounds to R1's left heel, right and left calves and coccyx. During observation on 2/27/24, at 10:07 a.m. R1 was laying in bed watching television. R1 had an air mattress on his bed and had protective boots on his feet. During interview on 2/28/24 at 7:59 a.m., nurse practitioner (NP)-A stated on 2/16/24, she was in the facility and was called in to do a skin assessment on R1. NP-A stated she had seen some changes in R1's skin integrity and a lapse of treatment prevention interventions. NP-A said R1 was not wearing his heel protectors and had a pillow behind him but said the repositioning wedges had been shoved under a television stand. NP-A stated R1 had a lot of new skin integrity issues and said "things were not being done." NP-A said with R1's condition she would have expected some decline but not to the degree she saw. NP-A said she questioned if R1 was being repositioned, received adequate hygiene assistance and said he should have had an air mattress. On 2/28/24 at 2:04 p.m., the director of nursing stated R1 had come from the hospital with a wound on his coccyx and had a treatment plan in place. The DON stated she knew R1's heels had been boggy upon admission but said prior to the assessment on 2/16/24, she had not been aware	F 686		

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F 686	Continued From page 14 the wounds had progressed. The DON stated on 2/16/24, they had found wounds on R1's heels had opened and he had wounds on his shins, calves and back. The DON stated routine skin inspections had not been completed and documentation was lacking following the identification of the wounds and the care plan lacked interventions. The DON stated when a wound was noted, the nurse should have completed an incident report and immediate interventions should have been implemented. The DON stated they were working on education for staff. The DON stated after R1's wounds were assessed the facility made sure all residents had skin assessments completed. During interview on 2/29/24 at 10:30 a.m., nursing assistant (NA)-D stated R1's skin could breakdown very easily if he was not repositioned every two hours. NA-D stated R1 was not able to make significant changes in his position on his own. During interview on 2/29/24 at 10:38 a.m., RN-B stated she had documented the skin assessment on 2/22/24, but stated she had not actually seen R1's skin. RN-B stated she had received the information from the hospice nurse to complete the documentation. R4's quarterly MDS dated 2/15/24, identified severe cognitive impairment and indicated she was dependent on staff for toileting, repositioning and transfers. R4's MDS identified a stage II pressure ulcer. R4's care plan dated 11/21/23, indicated potential for alteration in skin integrity due to limited mobility, pain, incontinence and diabetes. The	F 686		

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F 686	Continued From page 15 care plan identified a history of pressure ulcers to R4's coccyx. The care plan directed staff to assist R4 to turn and reposition every two hours while sitting and while lying down. During continuous observation on 2/28/24, at 8:56 a.m. R4 was seated in the dining room in her wheelchair finishing breakfast. Underneath R4 in her chair was a mechanical lift sling. At 9:07 a.m. a staff member escorted R4 to her room and placed her in front of the television. At 9:52 a.m. a nurse entered the room to administer insulin then left. At 9:58 a.m. NA-A looked into the room but did not enter. At 11:26 a.m. R4 remained seated in her wheelchair in her room with no offers of repositioning. During interview and continuos observation at 11:31 a.m., NA-A stated R4 required total assistance from staff. NA-A stated R4 usually hung out in her wheelchair between breakfast and lunch then laid down after lunch. NA-A said R4 had a sore on her bottom and said her care plan indicated she should be repositioned every two hours. NA-A stated the last time R4 had been repositioned was around 8:00 a.m. At 11:37 a.m. NA-A and RN-A assisted R4 to lay down on the bed. RN-A removed an adhesive dressing from R4's buttocks performed a skin inspection which revealed a large area of scarring from previous ulcers and a scabbed over area approximately 1 cm x .5 cm. RN-A said R4 had a history of pressure ulcers that "come and go." NA-A stated R4 should be repositioned every two hours. Facility Policy Pressure Ulcers dated 2/1/24,identified guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers and indicated the following	F 686		

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	245039	A. BUILDING _____ B. WING _____	C 02/29/2024

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F 686	Continued From page 16 information should be recorded in the resident ' s medical record: All assessment data (i.e., color, size, pain, drainage, etc.) when inspecting the wound.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess, develop and implement interventions to reduce the risk for falls for 1 of 3 residents (R2) who had repeated falls with fractures. This resulted in actual harm for R2 who sustained a fractured nasal bone, fractured vertebrae and fractured rib. In addition, the facility failed to ensure safe use of mechanical lift devices for 3 of 3 residents (R2, R4, R5) reviewed. This resulted in further harm to R2 who fell from a EZ Lift Stand and sustained a broken clavicle (collarbone). Findings include: R2's significant change Minimum Data Set (MDS) dated 1/30/24, identified intact cognition and indicated he was independent with transfers, toileting, and dressing. The MDS indicated he required moderate assistance for showers. R2's MDS further identified a fall with fracture prior to	F 689	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Staff have been educated on safe resident transfer (R2) on mechanical lift per manufacture guidelines. Also, a comprehensive falls assessment including analysis of the cause of falls was completed for R2. Fall interventions were reviewed to ensure they accurately reflect the falls assessment and provide adequate supervision to prevent recurrent falls. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected by the deficient practice. To identify other residents to have been	3/22/24

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F 689	Continued From page 17 admission and indicated he had not had a fall since the prior assessment. R2's care plan dated 1/26/24, identified a potential for falls due to history of falls, medications, pain, weakness, heart and kidney disease. Interventions included: 12/15/23, keep wheelchair at bedside when not in use.,1/5/24, initiate and reinforce safety teaching, 1/5/24, walker, urinal at bedside. 1/26/22, frequent purposeful rounding. make sure resident has pendent call light. R2's medical record lacked evidence of a comprehensive assessment of his falls. Facility Healthcare Safety Zone (incident report) dated 12/14/23, indicated R2 called for staff assistance around 4:45 a.m.. R2 was seated on the floor next to his bed with his wheelchair behind him. There was a pool of blood next to R2, his nose was bleeding, he had a large skin tear by his left elbow and his right big toe was bleeding. R2 reported he had a nightmare, rolled over and woke up on the floor. Interventions placed prior to the fall included: personal items in reach, evaluate for environmental hazards, remind to call for assistance, personal alarm in bed and ensure wheel chair brakes are locked at all times. Interventions placed following the fall included bed/chair alarms and education. R2' facility Progress Note dated 12/14/23, indicated R2 returned from the emergency department (ED) around 6:30 p.m. R2 returned with a cervical thoracic orthosis (CTO) brace. (A neck brace that has an extension support to also protect the thoracic spine).	F 689	affected by the deficient practice the Director of Nursing/designee will review all current residents with a history of falls by 3/22/2024 to ensure their falls assessment includes an analysis of the cause of the fall(s). Residents fall interventions will be reviewed to ensure they accurately reflect the falls assessment and provide adequate supervision as applicable to prevent recurrent falls. Care plans for all residents that use mechanical lifts were updated to ensure proper sling size is used during transfers. On 2/28/24 the incorrect sized sling was removed from R4’s room and replaced with correct sling size. R4’s care plan was updated to reflect the correct sling size. The sling size was added to the POC sheet. On 2/28/2024 R5’s care plan was updated to reflect mechanical lift for transfer with correct sling size. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained , all nursing staff will be educated on Safe Resident Handling practices and training related to safe use of lift machines based on manufacturers guidelines .Training will include but not limited to following resident plan of care/service plan for mobility device, type and size of sling and number of	

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F 689	Continued From page 18 Healthcare Safety Zone dated 12/19/23, indicated R2 slid off his shower bench to the shower floor. R2 called out for help and was found on the floor. R2 had old bruising under his eyes and a skin tear from his previous fall. The report did not include interventions following the fall. Healthcare Safety Zone dated 12/25/23, indicated R 2 was found on the floor in the bathroom at 5:30 a.m. It appeared his wheelchair brakes were not locked as chair was across the room. No injuries noted at the time. R2 did not have call light on and no gripper socks on his feet. The fall report did not include interventions following the fall. R2's Progress Note dated 12/26/23, indicated he slid off his bench in the shower. Nurse educated from now on staff needed to sit with R2 for safety purposes. Care plan lacked evidence interventions were implemented. R2's Event Report dated 1/19/24, identified a fall at 2:30 a.m. The report indicated R2 was found on the bathroom floor and complained of pain in his ribs on the left side. R2 was reminded to use his call light for assistance with transfers and toileting. R2's Progress Note dated 1/19/24, indicated he returned from the ED at approximately 2:20 p.m. R2 was diagnosed with a rib fracture. Encourage use of brace and to deep breath and cough every hour to prevent collapse of lungs and use pillow to help ease pain. R2's Progress Note dated 1/27/24, indicated he self-transferred to his bed and fell. R2 hit his call light and it got disconnected. Staff in next room	F 689	employees to safely transfer or position resident. Also, the Director of Nursing/designee will review facility's policy on falls (including the development and implementation of an interdisciplinary team process to review, analyze and evaluate falls and other related incidents) and educate all nursing staff on the facility's falls policy and safe resident handling practices. The interdisciplinary team will review, analyze and evaluate falls to ensure the residents environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents, and that an analysis of the cause of falls is conducted after each fall occurrence. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The Director of Nursing/designee will audit all residents weekly for 6 weeks who have fallen to ensure their fall was analyzed for the cause of the fall, their assessment accurately identifies fall risks and their care plan provides individualized interventions to ensure their environment remains as free of accident hazards as is possible and they receive adequate supervision and assistance devices to prevent accidents. Results will be forwarded to the QAPI committee for further recommendations. Director of Nursing/Designee will audit 5 resident transfers weekly, for 6 weeks to ensure	

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F 689	Continued From page 19 responded and found R2 on the floor with his upper body leaning on the bed. R2's right toes were stuck under his wheel chair. R2 complained of pain in his knees which were red and swollen with an indent in the right knee. No intervention noted. During interview on 2/27/24 at 3:08 p.m., R2's falls were reviewed with the director of nursing (DON). The DON stated when a resident fell, the nurse in charge should place immediate interventions, then the interdisciplinary team (IDT) would review and update care plans and care sheets. The DON stated when R2 fell on 12/14/23, he sustained a fractured vertebrae and broke his nose. The DON said at that time they discussed therapy because R2 had become more weak and had been hospitalized multiple times. The DON stated the care plan was updated to include increased supervision and to have his wheel chair next to his bed. The DON stated on 12/19/23, R2 slid off his shower bench and staff were directed not to leave him alone in the shower. (Record lacked evidence this was care planned). The DON stated R2 was found on the floor in his bathroom on 12/25/23, and said his wheelchair brakes were not locked and he did not have non slip footwear on. The DON said they encouraged the use of non slip socks. The DON stated when R2 fell off the shower bench the second time on 12/26/23, there was no evidence the IDT had reviewed the fall. Following the fall on 1/19/24, the DON stated R2 was hospitalized for respiratory failure and COVID. The DON said R2 returned to the facility on 1/24/24, and said he was still able to move around the facility and was given a pendant style call light and reminders to use it. Following the fall on 1/27/24, the DON stated there was no evidence the fall was	F 689	staff are following the care plan when transferring residents. What is the date of completion? 3/22/2024	

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F 689	Continued From page 20	F 689		

reviewed. The DON stated there was missing documentation in progress notes and the Health Safety Zone reports and confirmed a comprehensive assessment of R2's fall had not been completed.

Fall from lift

Healthcare Safety Zone dated 2/5/24, indicated staff was assisting R2 to the bathroom using a mechanical stand. R2 let go of the handles and began to slide out of the stand. Staff was able to guide R2 to the floor. R2 sustained a skin tear and complained of pain in his right shoulder. R2 was sent to the emergency department after dialysis.

During observation and interview on 2/27/24 at 1:10 p.m., R2 was laying on his back in bed. R2 was asked how he was doing and replied "terrible, I have a broken collarbone, and a broken rib." R2 stated when he broke his collar bone, "they raised me up in the lift and it dropped. Not sure what happened, I probably slid out of it." R2 stated before he came to the facility he could walk with a walker and now he couldn't do anything. He sated he couldn't stand and used a machine to transfer. R2 said, "If I break another bone they might as well shoot me."

During interview on 2/27/24 at 2:23 p.m., trained medication aide (TMA)-A stated most of R2's falls had been on his dialysis days when staff were getting him up. TMA-A said the last one was from the mechanical stand and said he was not sure of the details but said that was how R2 got the broken clavicle. TMA-A said R2 now required a mechanical lift to transfer. TMA-A said prior to the fall from the stand they kept his wheel chair close,

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F 689	Continued From page 21 did frequent rounding and made sure his call light was in reach. TMA-A stated before R2 began falling he had been very independent. TMA-A said R2 had not been walking but was independent with transfers and toileting. During interview on 2/27/24 at 3:08 p.m., the DON stated when R2 fell from the mechanical stand on 2/5/24, it looked like he let go of the handles and staff guided him to the floor. The DON stated R2 sustained a skin tear and a broken collarbone. The DON stated an investigated into the details of the fall had not been completed. During interview on 2/27/24 at approximately 3:45 p.m., licensed practical nurse (LPN)-A stated normally R2 required assistance from one to two staff but had been having a hard time so on 2/5/24, she transferred him to the bathroom using the mechanical stand. LPN-A stated when she was bringing R2 to the bathroom his arms lifted and he fell through the lift. LPN-A said she had the harness secured around R2 but said it may have loosened when he was stood up. LPN-A stated she had not secured the calf strap when R2 was in the lift. LPN-A said no one from the facility had asked her about the details of the incident but said she did not feel the lift had malfunctioned in any way. LPN-A said R2 now required the use of a ceiling lift for transfers. R4's care plan dated 2/12/24, identified a self care deficit due to cerebral vascular accident with left sided weakness. The care plan directed staff to provide assist of one staff and Sara Stedy (a manual sit-to-stand transfer aid) or easy mover (mechanical stand aid) to transfer R4 to the toilet.	F 689		

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F 689	Continued From page 22 An untitled facility care sheet dated 2/14/24, indicated R4 used a mechanical lift for transfers. The care sheet did not specify a sling size for R4. During observation and interview on 2/28/24 at 11:37 a.m., nursing assistant (NA)-A and registered nurse (RN)-A assisted R4 to transfer from wheelchair to bed using a mechanical lift. While lifting R4 up in the lift, the sling appeared too big. The sling was a split leg design but instead of bringing each strap under R4's legs and crossing them in the middle, each strap was brought under both of R4's legs and hooked to the lift. After R4 was laying on the bed NA-A and RN-A were asked about the sling size. NA-A looked at the sling and stated it was size large. NA-A stated the slings were based on weight and when asked if she knew if R4's sling was correct based on her weight she stated should would have to ask the nurse how much R4 weighed. When asked about the position of the leg straps, RN-A stated she would have to do some research. NA-A and RN-A then transferred R4 back to the chair the same way. During interview on 2/28/24 at 12:36 p.m., the facilities EZ- Lift representative stated if a fall occurred from a mechanical stand it could have been the straps were not properly attached. The representative said if the harness was still attached, likely the resident was not properly situated in the sling. The representative stated a resident should never slide out of the harness if it was the correct size and attached properly to the lift and the patient. In regard to the mechanical lift slings, the representative stated the slings should be used the way they were designed and said if they were not applied properly or not the correct size it could cause accidents.	F 689		

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F 689	Continued From page 23 R5's care plan dated 2/14/24, identified a self care deficit due to dementia and directed staff to assist with transfer using one staff and a Sara Stedy. An untitled, undated facility care sheet, received on 2/28/24, indicated R5 used a mechanical lift for transfer. The sheet indicated "make sure medium lift sling is used." During observation on 2/28/24 at 1:30 p.m., NA-B and NA-C transferred R5 from wheelchair to bed using a ceiling lift. R5 was using a mesh, split leg sling with blue straps. The label on the sling was missing. NA-B stated the sling was a large and said the medium slings had yellow straps. NA-B further stated he thought a medium sling would be good for R5 and said, "this one is a little big." During interview on 2/28/24 at 1:52 p.m., RN-A stated the sling used to transfer R4 had been the wrong size and said the strap positioning was not done according to manufacturers instruction. An undated facility document titled EZ-Stand Transfer, directed staff to bring the lift as close to the patient as possible. Place the harness around the patient, fasten the safety harness, secure the strap and pull it tight to fit. Place feet on the foot plate and attach the shin strap. When lifting the patient up simultaneously tighten the safety strap fastened around the patients torso. A facility document titled kwikpoint Patient Lifts Safety Guide undated, indicated using the wrong sling or attaching the sling incorrectly may cause serious injury to the caregiver or patient.	F 689		

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F 689	Continued From page 24 Facility policy Fall Prevention And Management dated 3/29/23, indicated if the fall involves a medical device secure the device and any parts or accessories for follow up investigation and report to the administrator.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/27/24 through 2/29/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H50391188C (MN100026) The following complaints were reviewed. H50391140C (MN100954) with a licensing order issued at 0830. H50391161C (MN100611) with a licensing order issued at 0830. H50391187C (MN100613, MN99254) with a licensing order issued at 0830. As a result of the survey additional orders were cited at 1980, 1930. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

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2 000	Continued From page 2 electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: FALLS Based on observation, interview and document review the facility failed to assess, develop and implement interventions to reduce the risk for falls	2 830	Corrected	3/22/24

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2 830	Continued From page 3 for 1 of 3 residents (R2) who had repeated falls with fractures. This resulted in actual harm for R2 who sustained a fractured nasal bone, fractured vertebrae and fractured rib. In addition, the facility failed to ensure safe use of mechanical lift devices for 3 of 3 residents (R2, R4, R5) reviewed. This resulted in further harm to R2 who fell from a EZ Lift Stand and sustained a broken clavicle (collarbone). Findings include: R2's significant change Minimum Data Set (MDS) dated 1/30/24, identified intact cognition and indicated he was independent with transfers, toileting, and dressing. The MDS indicated he required moderate assistance for showers. R2's MDS further identified a fall with fracture prior to admission and indicated he had not had a fall since the prior assessment. R2's care plan dated 1/26/24, identified a potential for falls due to history of falls, medications, pain, weakness, heart and kidney disease. Interventions included: 12/15/23, keep wheelchair at bedside when not in use.,1/5/24, initiate and reinforce safety teaching, 1/5/24, walker, urinal at bedside. 1/26/22, frequent purposeful rounding. make sure resident has pendent call light. R2's medical record lacked evidence of a comprehensive assessment of his falls. Facility Healthcare Safety Zone (incident report) dated 12/14/23, indicated R2 called for staff assistance around 4:45 a.m.. R2 was seated on the floor next to his bed with his wheelchair behind him. There was a pool of blood next to R2, his nose was bleeding, he had a large skin tear	2 830		

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2 830	Continued From page 4 by his left elbow and his right big toe was bleeding. R2 reported he had a nightmare, rolled over and woke up on the floor. Interventions placed prior to the fall included: personal items in reach, evaluate for environmental hazards, remind to call for assistance, personal alarm in bed and ensure wheel chair brakes are locked at all times. Interventions placed following the fall included bed/chair alarms and education. R2' facility Progress Note dated 12/14/23, indicated R2 returned from the emergency department (ED) around 6:30 p.m. R2 returned with a cervical thoracic orthosis (CTO) brace. (A neck brace that has an extension support to also protect the thoracic spine). Healthcare Safety Zone dated 12/19/23, indicated R2 slid off his shower bench to the shower floor. R2 called out for help and was found on the floor. R2 had old bruising under his eyes and a skin tear from his previous fall. The report did not include interventions following the fall. Healthcare Safety Zone dated 12/25/23, indicated R 2 was found on the floor in the bathroom at 5:30 a.m. It appeared his wheelchair brakes were not locked as chair was across the room. No injuries noted at the time. R2 did not have call light on and no gripper socks on his feet. The fall report did not include interventions following the fall. R2's Progress Note dated 12/26/23, indicated he slid off his bench in the shower. Nurse educated from now on staff needed to sit with R2 for safety purposes. Care plan lacked evidence interventions were implemented. R2's Event Report dated 1/19/24, identified a fall	2 830		

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2 830	Continued From page 5 at 2:30 a.m. The report indicated R2 was found on the bathroom floor and complained of pain in his ribs on the left side. R2 was reminded to use his call light for assistance with transfers and toileting. R2's Progress Note dated 1/19/24, indicated he returned from the ED at approximately 2:20 p.m. R2 was diagnosed with a rib fracture. Encourage use of brace and to deep breath and cough every hour to prevent collapse of lungs and use pillow to help ease pain. R2's Progress Note dated 1/27/24, indicated he self-transferred to his bed and fell. R2 hit his call light and it got disconnected. Staff in next room responded and found R2 on the floor with his upper body leaning on the bed. R2's right toes were stuck under his wheel chair. R2 complained of pain in his knees which were red and swollen with an indent in the right knee. No intervention noted. During interview on 2/27/24 at 3:08 p.m., R2's falls were reviewed with the director of nursing (DON). The DON stated when a resident fell, the nurse in charge should place immediate interventions, then the interdisciplinary team (IDT) would review and update care plans and care sheets. The DON stated when R2 fell on 12/14/23, he sustained a fractured vertebrae and broke his nose. The DON said at that time they discussed therapy because R2 had become more weak and had been hospitalized multiple times. The DON stated the care plan was updated to include increased supervision and to have his wheel chair next to his bed. The DON stated on 12/19/23, R2 slid off his shower bench and staff were directed not to leave him alone in the shower. (Record lacked evidence this was care	2 830		

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2 830	Continued From page 6 planned). The DON stated R2 was found on the floor in his bathroom on 12/25/23, and said his wheelchair brakes were not locked and he did not have non slip footwear on. The DON said they encouraged the use of non slip socks. The DON stated when R2 fell off the shower bench the second time on 12/26/23, there was no evidence the IDT had reviewed the fall. Following the fall on 1/19/24, the DON stated R2 was hospitalized for respiratory failure and COVID. The DON said R2 returned to the facility on 1/24/24, and said he was still able to move around the facility and was given a pendant style call light and reminders to use it. Following the fall on 1/27/24, the DON stated there was no evidence the fall was reviewed. The DON stated there was missing documentation in progress notes and the Health Safety Zone reports and confirmed a comprehensive assessment of R2's fall had not been completed. Fall from lift Healthcare Safety Zone dated 2/5/24, indicated staff was assisting R2 to the bathroom using a mechanical stand. R2 let go of the handles and began to slide out of the stand. Staff was able to guide R2 to the floor. R2 sustained a skin tear and complained of pain in his right shoulder. R2 was sent to the emergency department after dialysis. During observation and interview on 2/27/24 at 1:10 p.m., R2 was laying on his back in bed. R2 was asked how he was doing and replied "terrible, I have a broken collarbone, and a broken rib." R2 stated when he broke his collar bone, "they raised me up in the lift and it dropped. Not sure what happened, I probably slid out of it." R2 stated before he came to the facility he could	2 830		

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2 830	Continued From page 7 walk with a walker and now he couldn't do anything. He sated he couldn't stand and used a machine to transfer. R2 said, "If I break another bone they might as well shoot me." During interview on 2/27/24 at 2:23 p.m., trained medication aide (TMA)-A stated most of R2's falls had been on his dialysis days when staff were getting him up. TMA-A said the last one was from the mechanical stand and said he was not sure of the details but said that was how R2 got the broken clavicle. TMA-A said R2 now required a mechanical lift to transfer. TMA-A said prior to the fall from the stand they kept his wheel chair close, did frequent rounding and made sure his call light was in reach. TMA-A stated before R2 began falling he had been very independent. TMA-A said R2 had not been walking but was independent with transfers and toileting. During interview on 2/27/24 at 3:08 p.m., the DON stated when R2 fell from the mechanical stand on 2/5/24, it looked like he let go of the handles and staff guided him to the floor. The DON stated R2 sustained a skin tear and a broken collarbone. The DON stated an investigated into the details of the fall had not been completed. During interview on 2/27/24 at approximately 3:45 p.m., licensed practical nurse (LPN)-A stated normally R2 required assistance from one to two staff but had been having a hard time so on 2/5/24, she transferred him to the bathroom using the mechanical stand. LPN-A stated when she was bringing R2 to the bathroom his arms lifted and he fell through the lift. LPN-A said she had the harness secured around R2 but said it may have loosened when he was stood up. LPN-A stated she had not secured the calf strap when	2 830		

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2 830	Continued From page 8 R2 was in the lift. LPN-A said no one from the facility had asked her about the details of the incident but said she did not feel the lift had malfunctioned in any way. LPN-A said R2 now required the use of a ceiling lift for transfers. R4's care plan dated 2/12/24, identified a self care deficit due to cerebral vascular accident with left sided weakness. The care plan directed staff to provide assist of one staff and Sara Stedy (a manual sit-to-stand transfer aid) or easy mover (mechanical stand aid) to transfer R4 to the toilet. An untitled facility care sheet dated 2/14/24, indicated R4 used a mechanical lift for transfers. The care sheet did not specify a sling size for R4. During observation and interview on 2/28/24 at 11:37 a.m., nursing assistant (NA)-A and registered nurse (RN)-A assisted R4 to transfer from wheelchair to bed using a mechanical lift. While lifting R4 up in the lift, the sling appeared too big. The sling was a split leg design but instead of bringing each strap under R4's legs and crossing them in the middle, each strap was brought under both of R4's legs and hooked to the lift. After R4 was laying on the bed NA-A and RN-A were asked about the sling size. NA-A looked at the sling and stated it was size large. NA-A stated the slings were based on weight and when asked if she knew if R4's sling was correct based on her weight she stated should would have to ask the nurse how much R4 weighed. When asked about the position of the leg straps, RN-A stated she would have to do some research. NA-A and RN-A then transferred R4 back to the chair the same way. During interview on 2/28/24 at 12:36 p.m., the facilities EZ- Lift representative stated if a fall	2 830		

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2 830	Continued From page 9 occurred from a mechanical stand it could have been the straps were not properly attached. The representative said if the harness was still attached, likely the resident was not properly situated in the sling. The representative stated a resident should never slide out of the harness if it was the correct size and attached properly to the lift and the patient. In regard to the mechanical lift slings, the representative stated the slings should be used the way they were designed and said if they were not applied properly or not the correct size it could cause accidents. R5's care plan dated 2/14/24, identified a self care deficit due to dementia and directed staff to assist with transfer using one staff and a Sara Stedy. An untitled, undated facility care sheet, received on 2/28/24, indicated R5 used a mechanical lift for transfer. The sheet indicated "make sure medium lift sling is used." During observation on 2/28/24 at 1:30 p.m., NA-B and NA-C transferred R5 from wheelchair to bed using a ceiling lift. R5 was using a mesh, split leg sling with blue straps. The label on the sling was missing. NA-B stated the sling was a large and said the medium slings had yellow straps. NA-B further stated he thought a medium sling would be good for R5 and said, "this one is a little big." During interview on 2/28/24 at 1:52 p.m., RN-A stated the sling used to transfer R4 had been the wrong size and said the strap positioning was not done according to manufacturers instruction. An undated facility document titled EZ-Stand Transfer, directed staff to bring the lift as close to the patient as possible. Place the harness around	2 830		

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2 830	Continued From page 10 the patient, fasten the safety harness, secure the strap and pull it tight to fit. Place feet on the foot plate and attach the shin strap. When lifting the patient up simultaneously tighten the safety strap fastened around the patients torso. A facility document titled kwikpoint Patient Lifts Safety Guide undated, indicated using the wrong sling or attaching the sling incorrectly may cause serious injury to the caregiver or patient. Facility policy Fall Prevention And Management dated 3/29/23, indicated if the fall involves a medical device secure the device and any parts or accessories for follow up investigation and report to the administrator. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. 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 Based on observation, interview and document review the facility failed monitor and develop and implement interventions to reduce the risk of pressure ulcers for 2 of 3 residents (R1,R4) reviewed. This resulted in actual harm to R1 who developed new and worsening pressure ulcers. Findings include:	2 830		

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2 830	Continued From page 11 R1 Admission Observation dated 1/2/24, identified bruises and pressure sores. The observation did not identify location, size or stage of pressure sores. R1's Skin Risk Assessment dated 1/2/24 indicated a Braden Scale for predicting pressure ulcer risk identifed a score of 13, inidcating he was at moderate risk for skin breakdown. R1's Physician Order Report dated 1/2/24 through 2/29/24, identified an order dated 1/2/24, that indicated: weekly skin check. Special instructions: Use wound management module to document wounds/ulcers. R1's Admission Minimum Data Set (MDS) dated 1/8/24, identified intact cognition and indicated he did not display rejection of care behaviors. The MDS indicated R1 had upper and lower extremity impairments and required substantial/maximal assistance with toileting, had an indwelling catheter and was continent of bowel. R1's pressure ulcer care plan created 2/19/24, indicated R4 had deep tissue injuries, pressure ulcers, and areas of maceration. the care plan directed staff to turn and reposition every two hours, perform wound observations as ordered and as needed, assess the pressure ulcer for location, stage, size (length, width,and depth), presence/absence of granulation tissue and epithelia at least weekly or as ordered and avoid friction and shearing forces during transfers or position changes. R1's Progress Notes identified the following: 1/2/24, indicated R1 had a stage II (arterial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without	2 830		

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2 830	Continued From page 12 slough [type of nonviable tissue that occurs as a byproduct of the inflammatory process] or bruising) pressure sore to his coccyx that measured approximately 1 centimeter (cm) x 0.4 cm, wound bed red with minimal slough noted, surrounding skin had bleachable redness, R1 to be turned every two hours or as needed, heels were boggy and had blanchable redness. A correlating Wound Management Report identified a stage II pressure ulcer on R1's coccyx measuring 1 cm x .4 cm with a light amount of exudates. Tissue type indicated slough. 1/11/24, Wound on coccyx is covered with Mepilex. Nurse did not get measurements of wound. Wound has Sanguineous drainage (refers to the leakage of fresh blood produced by an open wound) absent edema and redness. The note lacked evidence a skin assessment was completed. 1/22/24, New Mepilex placed to coccyx and heels. The note lacked evidence a skin assessment was completed. 1/30/24, R1 continued with wound on coccyx, new Mepilex dressing applied to both coccyx and heels. The note lacked evidence a skin assessment was completed. 2/16/24. indicated R1's skin was assessed with physician and hospice nurse. R1 had a deep tissue injury (pressure ulcer in which area of skin may look purple or dark red, or there may be a blood-filled blister) to right calf that measure 9.5 cm x 0.5 cm, right heel had a non-stageable ulcer (full-thickness pressure injuries in which the base is obscured by slough and/or eschar) that measured 4.5 cm x 3 cm, left calf had a deep tissue injury that measured 6 cm x 1 cm, deep	2 830		

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2 830	Continued From page 13 tissue injury to left ankle measuring 3.5 cm x 0.5 cm, left heel had a non-stageable wound that measured 2.5 cm x 3 cm, right shin had a deep tissue injury measuring 5.5 cm x 1.2 cm, stage II pressure ulcer noted to left side of back measuring 1.5 cm x 1.8 cm, coccyx has non-blanchable redness/maceration, two open areas to coccyx that measured 1.5 cm x 0.7 cm with a depth of 0.2 cm, non-blanchable area to right gluteal cleft 1 cm x 1 cm. Each area cleansed with normal saline, Mepilex dressing applied to both heels, both calves, and on back, protective barrier applied to coccyx. physician ordered to wash resident up twice daily, change shirt daily, reposition-side to side every two hours and as needed. Correlating Wound Management Detail Reports dated 2/16/24, identified wounds to R1's left heel, right and left calves and coccyx. 2/22/24, Written by registered nurse (RN)-B Resident had a bed bath this morning, given by hospice nurse. Wounds were measured and Mepilex placed on his heels, back and right shin,. The other areas were left open to air. The areas measured as follows: Right calf 9.5 cm x 0.5 cm, right heel 4.5 cm x 4 cm, left calf 6 cm x 0.8, left ankle 3 cm x 0.5 cm, left heel 2 cm x 3 cm, right shin 5.4 cm x 1.2 cm , back 1 cm x 0.8 cm, coccyx scattered small openings, right gluteal cleft 0.8 cm x 0.7 cm. Other areas of his body are clear, no other open areas. Resident did not tolerate the treatment well, it was very painful. 2/22/24, written by RN-B, this nurse called hospice nurse to find out more extensive information about the wounds on this resident and her findings. Wound Management section charted. Correlating Wound Management Detail Reports dated 2/22/24, identified wounds to R1's left heel, right and left calves and coccyx.	2 830		

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2 830	Continued From page 14 During observation on 2/27/24, at 10:07 a.m. R1 was laying in bed watching television. R1 had an air mattress on his bed and had protective boots on his feet. During interview on 2/28/24 at 7:59 a.m., nurse practitioner (NP)-A stated on 2/16/24, she was in the facility and was called in to do a skin assessment on R1. NP-A stated she had seen some changes in R1's skin integrity and a lapse of treatment prevention interventions. NP-A said R1 was not wearing his heel protectors and had a pillow behind him but said the repositioning wedges had been shoved under a television stand. NP-A stated R1 had a lot of new skin integrity issues and said "things were not being done." NP-A said with R1's condition she would have expected some decline but not to the degree she saw. NP-A said she questioned if R1 was being repositioned, received adequate hygiene assistance and said he should have had an air mattress. On 2/28/24 at 2:04 p.m., the director of nursing stated R1 had come from the hospital with a wound on his coccyx and had a treatment plan in place. The DON stated she knew R1's heels had been boggy upon admission but said prior to the assessment on 2/16/24, she had not been aware the wounds had progressed. The DON stated on 2/16/24, they had found wounds on R1's heels had opened and he had wounds on his shins, calves and back. The DON stated routine skin inspections had not been completed and documentation was lacking following the identification of the wounds and the care plan lacked interventions. The DON stated when a wound was noted, the nurse should have completed an incident report and immediate interventions should have been implemented.	2 830		

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2 830	Continued From page 15 The DON stated they were working on education for staff. The DON stated after R1's wounds were assessed the facility made sure all residents had skin assessments completed. During interview on 2/29/24 at 10:30 a.m., nursing assistant (NA)-D stated R1's skin could breakdown very easily if he was not repositioned every two hours. NA-D stated R1 was not able to make significant changes in his position on his own. During interview on 2/29/24 at 10:38 a.m., RN-B stated she had documented the skin assessment on 2/22/24, but stated she had not actually seen R1's skin. RN-B stated she had received the information from the hospice nurse to complete the documentation. R4's quarterly MDS dated 2/15/24, identified severe cognitive impairment and indicated she was dependent on staff for toileting, repositioning and transfers. R4's MDS identified a stage II pressure ulcer. R4's care plan dated 11/21/23, indicated potential for alteration in skin integrity due to limited mobility, pain, incontinence and diabetes. The care plan identified a history of pressure ulcers to R4's coccyx. The care plan directed staff to assist R4 to turn and reposition every two hours while sitting and while lying down. During continuous observation on 2/28/24, at 8:56 a.m. R4 was seated in the dining room in her wheelchair finishing breakfast. Underneath R4 in her chair was a mechanical lift sling. At 9:07 a.m. a staff member escorted R4 to her room and placed her in front of the television. At 9:52 a.m. a nurse entered the room to administer insulin then	2 830		

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2 830	Continued From page 16 left. At 9:58 a.m. NA-A looked into the room but did not enter. At 11:26 a.m. R4 remained seated in her wheelchair in her room with no offers of repositioning. During interview and continuos observation at 11:31 a.m., NA-A stated R4 required total assistance from staff. NA-A stated R4 usually hung out in her wheelchair between breakfast and lunch then laid down after lunch. NA-A said R4 had a sore on her bottom and said her care plan indicated she should be repositioned every two hours. NA-A stated the last time R4 had been repositioned was around 8:00 a.m. At 11:37 a.m. NA-A and RN-A assisted R4 to lay down on the bed. RN-A removed an adhesive dressing from R4's buttocks performed a skin inspection which revealed a large area of scarring from previous ulcers and a scabbed over area approximately 1 cm x .5 cm. RN-A said R4 had a history of pressure ulcers that "come and go." NA-A stated R4 should be repositioned every two hours. Facility Policy Pressure Ulcers dated 2/1/24,identified guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers and indicated the following information should be recorded in the resident ' s medical record: All assessment data (i.e., color, size, pain, drainage, etc.) when inspecting the wound. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a	2 830		

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2 830	Continued From page 17 specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to operationalize their policy for prompt resolution of grievances for 1 of 1 residents (R3) reviewed who filed a grievance related to care concerns in the facility. Findings include: R3's Physician Orders dated January 2024, were reviewed. The orders did not include an order for Nitroglycerine tablets. A facility document titled Healthcare Safety Zone dated 2/1/24, indicated R3's family member	21870	Corrected	3/22/24

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21870	Continued From page 18 (FM)-A spoke about a medication (Nitroglycerine) they received a bill for. FM-A stated R3 did not have an order for the medication and said R3 told her the medication was in her medication cupboard and a nurse had tried to give her the medication but R3 had refused. FM-A further identified concerns related to supplies and a skin issue and the nurse on duty, when the skin issue was identified, stated she did not have time to look at. During interview on 2/29/24 at 11:08 a.m., FM-A stated the facility had not followed up with her about concerns as she had requested. During interview on 2/29/24 at 11:42 a.m., licensed social worker (LSW)-A stated the grievance was routed to the nurse manager, registered nurse (RN)-A for follow up because the concerns were clinical in nature. During interview on 2/29/24 at 12:45 p.m., RN-A stated she had looked into the concerns but did not have any supporting documentation. RN-A stated she was just putting the information into the follow up section of the grievance form today. During interview on 2/29/24 at 12:59 p.m., the administrator stated she thought RN-A was going to follow up with FM-A. The administrator stated she should have reviewed the grievance to ensure follow up. Facility Policy Resident Grievances dated 6/6/23, indicated a resident has the right to voice grievance to the facility or other agency. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished. A written grievance or an oral grievance which the resident	21870		

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21870	Continued From page 19 or resident representative states he/she wishes to be handled as a written grievance will be written and responded to in writing within seven days of receipt. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and develop a plan to ensure residents complaints and grievances are being addressed promptly. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) complaints and grievances are addressed on a timely basis. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21870		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the	21980		3/22/24

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21980	Continued From page 20 previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report a fall from a mechanical stand that resulted in a broken clavicle (collarbone) to the state agency (SA) for 1 of 3 residents (R2) reviewed for falls.	21980	Corrected	

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21980	Continued From page 21 Findings include: R2's care plan dated 1/26/24, identified a risk for falls and directed staff to offer assistance with activities of daily living and transfers. R2's Progress Note dated 2/5/24, indicated staff was assisting R2 to the bathroom using a mechanical stand. R2 let go of the handles and began to slide out of the stand. Staff was able to help guide R2 to the floor. R2 complained of right shoulder pain. R2 agreed to go to the emergency department after dialysis. During interview on 2/27/24 at 3:08 p.m., the director of nursing (DON) stated R2 sustained a skin tear and a broken clavicle. The DON stated the incident was not reported to the SA because staff had identified a decline in condition that contributed to his falls. During interview on 2/27/24 at approximately 3:30 p.m., the administrator stated R2's fall from the lift was not reported to the SA because staff assisted R2 during the fall. During interview on 2/28/24 at 12:36 p.m., the facilities EZ- Lift representative stated if a fall occurred from a mechanical stand it could have been the straps were not properly attached. The representative said if the harness was still attached, likely the resident was not properly situated in the sling. The representative stated a resident should never slide out of the harness if it was the correct size and attached properly to the lift and the patient. In regard to the mechanical lift slings, the representative stated the slings should be used the way they were designed and said if they were not applied properly or not the correct	21980		

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21980	Continued From page 22 size it could cause accidents. Facility policy Fall Prevention And Management dated 3/29/23, indicated if the fall involves a medical device secure the device and any parts or accessories for follow up investigation and report to the administrator. Report to the state regulatory agency when appropriate. A policy related to reporting to the SA was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility could re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits could be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits could be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		