

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 25, 2020

Administrator Pleasant Manor LLC 27 Brand Avenue Faribault, MN 55021

RE: CCN: 245090 Cycle Start Date: September 28, 2020

Dear Administrator:

On September 28, 2020 the Minnesota Department of Health completed a revisit of your facility. We have determined that your facility has achieved substantial compliance as of November 2, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective October 28, 2020 be discontinued as of November 2, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 13, 2020, 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), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 28, 2020. This does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: kamala.fiske-downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 13, 2020

Administrator Pleasant Manor LLC 27 Brand Avenue Faribault, MN 55021

RE: CCN: 245090 Cycle Start Date: September 28, 2020

Dear Administrator:

On September 28, 2020, a survey was completed at your facility by the Minnesota Department 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 28, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 28, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 28, 2020.

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 payment for new admissions.

Pleasant Manor LLC October 13, 2020 Page 2

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by October 28, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Pleasant Manor Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 28, 2020. 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.

Pleasant Manor LLC October 13, 2020 Page 3

- 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" tag) i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor Metro C District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: karen.aldinger@state.mn.us Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 28, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C)

Pleasant Manor LLC October 13, 2020 Page 4 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:

Tamika.Brown@cms.hhs.gov

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

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

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Pleasant Manor LLC October 13, 2020 Page 5

> 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Kumalu Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(<u>)MB NO</u>	. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION G) ´CON	E SURVEY MPLETED
		245090	B. WING	;			C / 28/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		20,2020
PLEASA	NT MANOR LLC				27 BRAND AVENUE		
					FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FC	00	0		
	survey was comple complaint investiga not to be in complia	0 and 9/28/20, an abbreviated ted at your facility to conduct a tion. Your facility was found ance with 42 CFR Part 483, ong Term Care Facilities.					
	The following comp substantiated: H5090056C at F68 H5090057C at F67 H5090059C at F67	77 and F725					
		laints were found to be 5090055C and H5090058C.					
F 550 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substat regulations has been your verification. Resident Rights/Ex	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with ercise of Rights	F٤	55	0		11/2/20
	self-determination, access to persons a	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE
Electron	ically Signed						10/30/2020

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

PRINTED: 11/02/2020

		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMI	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	§483.10(a)(1) A fac with respect and dig resident in a manner promotes maintena her quality of life, re- individuality. The fac promote the rights of §483.10(a)(2) The fac access to quality can severity of condition must establish and practices regarding provision of service residents regardless §483.10(b) Exercise The resident has the rights as a resident or resident of the Uf §483.10(b)(1) The fac resident can exercise interference, coerci- from the facility. §483.10(b)(2) The re- free of interference, reprisal from the fac rights and to be sup exercise of his or he subpart. This REQUIREMEN by: Based on observat review, the facility fac	 ility must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and of the resident. facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the es under the State plan for all s of payment source. e of Rights. e right to exercise his or her of the facility and as a citizen nited States. facility must ensure that the se his or her rights without on, discrimination, or reprisal resident has the right to be , coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this NT is not met as evidenced tion, interview, and document ailed to provide care in a ted dignity for 1 of 1 resident 	F 5	;50	F550=D. Based on observation, interview, and document review, the facility failed to provide care in a mathat promoted dignity for 1 of 1 resid (R7) reviewed for dignity concerns.	anner	

Facility ID: 00568

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	LTIPLE CONSTRUCTION	COM	E SURVEY PLETED C
		245090	B. WING	3		28/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
F 550	Findings include: R7's admission Min 7/28/20, included m with a diagnosis of incontinent and req person to transfer of R7's ADL (activities Rehab Care Assess dated 9/25/20, includ decline in mobility, w of bowel and bladde toileting upon reque R7's care plan date required assistance dependent assist, d personal hygiene se occasionally inconti with toilet use." When Interviewed of was lying in bed. R7 facility is very bad. If there seems to be r facility. Call lights ca hour. I push the call bathroom and no on wet myself. I feel h chair and embarrass cleaned up and chail brow was furled and R7 stated this happ When interviewed of nursing assistant (N wait for assistance	imum Date Set (MDS) dated noderate cognitive impairment a stroke. R7 was occasionally uired assistance by one staff on and off of the toilet. of daily living)/Functional sment Area Worksheet (CAA) ided, R7 has had a recent was occasionally incontinent er, and needed assistance for	F	 550 The residents of Pleasant Marright to receive care in a dignifil t is the responsibility of all star facility to ensure the residents care promotes their dignity and rights. The associated policies related providing care in a dignified m reviewed and remain appropris R7's plan of care for toileting v reviewed and remains appropricurrently level of function. All toileting plans have been revied discussed as an IDT and toilet appear to be appropriate at thi additionally will implement a R Advocate Program that will as promoting timely response to reconcerns. Education of executing a toilet care will be completed for all r and IDT will be educated on R Advocate Program. Administrator/DON or designe perform audits weekly x 4 weex x 3 months, and quarterly ther ensure compliance. Audit resure/reviewed monthly at QAPI meturther recommendations. Date of completion: 11/2/2020 	ied manner. if of the plan of d resident d to anner were ate. vas riate for resident's wed, ing plans s time. IDT esident sist in resident ing plan of ursing staff esident e will ks, monthly eafter to Its will be	

If continuation sheet Page 3 of 61

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Most residents wait time to receive an a has assisted R7 aft secondary to waitin time for the call ligh that there have bee beginning of the shi soiled and need as night shift is custom one licensed praction nurse (RN) for the 4 facility. When interviewed of LPN-D state there i individual needs of among staff and res R7 being incontinent to her timely is a dig R7's call light respon 9/22/20, at 3:51 a.m showed the call ligh the seven day period initiated, 11 (or 21.5 15 minutes to recein 14%) of these alerts to receive a respon During a phone call p.m. the administra staffing or facility as determining staffing administrator stated include one staff me "More comradery a was needed among	for an extended period of answer to their call light. NA-D er R7 was incontinent g for a prolonged period of t to be answered. NA-D stated n, "too many times," at the ift when several residents are sistance. NA-D stated the narily staffed with two NA's and cal nurse (LPN) or registered 42 current residents in the on 9/25/20, at 2:55 p.m. s insufficient staff to meet the each resident. The morale sidents is low because of this. It due to not being able to get gnity issue. Inse time logs dated from n. to 9/28/20, 9:25 a.m. it was engaged 51 times over od. Of the 51 call light alerts 5%) of these alerts took over ve a response. Seven (or s took longer than 20 minutes se. interview on 9/28/20, at 3:30 tor stated they do not have a ssessment in place to assist in g needs at this time. The d current staffing rations ember for every ten residents. nd better communication," g the staff. These measures a. The administrator stated that	F	550			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	Notice of Bed Hold CFR(s): 483.15(d)(Policy Before/Upon Trnsfr 1)(2)	Fe	625			11/2/20
	§483.15(d) Notice of	of bed-hold policy and return-					
	nursing facility trans the resident goes of nursing facility must the resident or reside specifies- (i) The duration of the any, during which the return and resume facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing fac bed-hold periods, w paragraph (e)(1) of resident to return; a	e before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the t provide written information to dent representative that the state bed-hold policy, if he resident is permitted to residence in the nursing 1 payment policy in the state 0 of this chapter, if any; ility's policies regarding which must be consistent with this section, permitting a and specified in paragraph (e)(1)					
	the time of transfer hospitalization or th facility must provide resident representa specifies the duration described in paragr This REQUIREMEN by: Based on document facility failed to issue	erapeutic leave, a nursing e to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section. NT is not met as evidenced ht review and interview, the e a written bed-hold notice hospital for 1 of 3 residents			F625=D. Based on document revision interview, the facility failed to issue written bed-hold notice upon transfer the hospital for 1 of 3 residents (R1 reviewed for hospitalizations. Prior to transfer, it is the responsibilithe Pleasant Manor staff to offer a w	a er to) lity of	

Facility ID: 00568

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625 F 677 SS=D	5/20/20, indicated F 5/14/20 with a disch anticipated MDS da R1's progress note included, R1 was tra- full report was given teams. However a b in R1's medical reco When interviewed of guardian reported s bed hold notification possibility to hold th When interviewed of interim director of n bed hold notice was Facility policy titled, Emergency revised bullet number 4: "TH responsible for: b. or her representativ readmission appeal ect." ADL Care Provided CFR(s): 483.24(a)(2) §483.24(a)(2) A res out activities of daily services to maintain personal and oral h	imum Data Set (MDS) dated A1 was admitted to facility on harge assessment-return hted, 9/16/20. dated 9/16/20, at 6:24 p.m. ansferred to the hospital and a in to the police and transport bed hold notice was not found ord. on 9/24/20, at 3:07 p.m. R1's the had not been provided a in and was unaware of the bed for R1. on 9/28/20, at 2:09 p.m. the ursing (DON) verified a written is not completed for R1. Transfer or Discharge, on 08/2018, indicated under the business office is Informing the resident, or his re (sponsor) of our facility's I rights, bed-holding policies, for Dependent Residents 2) ident who is unable to carry y living receives the necessary in good nutrition, grooming, and		\$25 \$77	bed-hold to the resident being trans The bed-hold policy has been review and remains appropriate. All nurses and IDT members will be educated on the bed-hold policy and steps to carry out offering a bed-hold during a transfer to the hospital. Administrator or designee will perfo audits weekly x 4 weeks, monthly x months, and quarterly thereafter to compliance. Audit results will be rev monthly at QAPI meetings for further recommendations. Completed 11/2/2020	wed d the ld rm 3 ensure <i>i</i> ewed	11/2/20
	by: Based on observat	ion, interview, and document ailed to provide incontinence			F677=D. Based on observation, interview, and document review, the	e	

Facility ID: 00568

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		& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	OMB NO.	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	· ·	NG		PLETED	
					(C	
		245090	B. WING _		•	09/28/2020	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	ZIP CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE	
F 677	Continued From pa	ige 6	F 67	77			
	care timely, and fai status after a signif residents (R3) revise Findings include: R4's admission Mir 6/29/20, included, r with diagnoses inclu- arthritis. R4 require toileting and limited hygiene. R4 was n was occasionally in times during the as R4's incontinence (dated 7/1/20 indica urinary incontinence assistance with toile incontinence." "She and OT [occupation the goal of returning uses incontinence [dry. Plan to continu and complete period HS [night], and with R4's significant chai included severe con dependent upon sta hygiene and was all R4's incontinence (led to reassess continence icant change for 1 of 3 ewed for incontinence. himum Data Set (MDS) dated moderate cognitive impairment uding diabetes, dementia and ed extensive assistance with l assistance with personal ot on a toileting program and continent of urine (less than 7 sessment period). Care Area Assessment (CAA) ted, "Resident triggers for e r/t [related to] need for et use and bladder e is in PT [physical therapy] nal therapy] at this time with g to the community. Resident products to aid in keeping skin te to with current toileting plan cares q [every] AM [morning], n each incontinent episode." ange MDS dated 8/27/20, gnitive impairment, was totally aff for toileting and personal ways incontinent of urine. CAA dated 8/28/20 included,		facility failed to provide timely, and failed to rea status after a significar residents (R4) reviewe Pleasant Manor staff h responsibility to provide who are unable to carr daily living to promote including assessment of and providing care dail The associated policies plans have been review appropriate. R4's toile reviewed and updated. toileting plans have beed discussed as an IDT at appear to be appropria Staff will be educated of toileting plans per plan DON or designee will p weekly x 4 weeks, mor and quarterly thereafte compliance. Audit resu monthly at QAPI meeti recommendations. Completed 11/2/2020	assess continence at change for 1 of 3 d for incontinence. ave the e care to residents y out activities of their health, during their stay y. s related to toileting wed and remain ting plan was All resident's en reviewed, nd toileting plans te at this time. on executing of care. erform audits thly x 3 months, r to ensure Its will be reviewed		
	"Resident triggers f toilet use and bladd declined in both mo She has recently en life cares. Resident	Francisco 2012/2010/2010/2010/2010/2010/2010/2010					

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		AND HUMAN SERVICES				FORM	: 11/02/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	[every] AM [morning incontinent episode R4's only Bowel and medical record was R4 was continent of R4's care plan date "Alteration with elimito, "Assist of 1 with not been updated s 8/27/20, MDS noted incontinence to total in assistance needs hygiene. R4's nursing assistants ambulate." No informursing assistants of toileting needs. During continuous of starting at 10:34 a.r if she would like to be declined. No encoup provided. No addition incontinence caress licensed practical nicher room to check be insulin. LPN-D then room. Incontinence	ant Care Sheet included, er [mechanical lift]; does not rmation was included to direct on how to attend to R4's observation on 9/25/20, m. 2 staff members asked R4 lay down. R4 verbally ragement or re-approach was onal attempts to provide occurred. At 11:46 a.m. urse (LPN)-D brought R4 to blood sugar and administer o brought R4 to the dining cares were not provided. At d NA-B assisted R4 linto bed	F	577			
	and NA-B stated the	on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with :30 a.m. NA-F stated they had					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 11/02/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245090	B. WING _		C 09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 677	since getting her up "There are only two best, it is terrible." I we can't get to her, NA-B acknowledge without being assist When interviewed of director of nursing (should be assisted hours. The DON st needs very well. Re was present review and Bladder assess 6/24/20, noting it in bladder. RN-A revie identified R4 had no Bladder assessmer significant decline in June of 2020. RN-7 an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least ev The facility policy To 11/2019) identified, incontinence produc change as needed. Planning" (revision care plan is to be m condition and care in changes."	ist R4 to lie down or toilet o at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. on 9/28/20, at 3:05 p.m. the DON) stated, she thought R4 with incontinent cares every 2 rated she did not know R4's egistered nurse (RN)-A who ved R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and ot had an updated Bowel and ht, even though she had a in condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4	F 67	77		11/2/20
	Treatment/Svcs to I CFR(s): 483.25(b)(F 68	80		11/2/20

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		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 11/02/2020 RM APPROVED NO. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l` í		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245090	B. WING	i		C 09/28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From pa	ge 9	F6	586		
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review, the facility fa timely for 1 of 3 res were at risk of deve Findings include: R4's significant cha dated 8/27/20, inclu impairment with a of required extensive total staff assistance for pressure ulcer of a current pressure ulcer (CAA) dated 8/28/2 for pressure r/t [rela with bed mobility ar incontinence. Resid down r/t cognitive ir	sure ulcers. rehensive assessment of a must ensure that- es care, consistent with rds of practice, to prevent does not develop pressure dividual's clinical condition hey were unavoidable; and ressure ulcers receives at and services, consistent andards of practice, to event infection and prevent veloping. NT is not met as evidenced ion, interview, and document ailed to provide repositioning idents (R4) reviewed who loping pressure ulcers.			F686=D. Based on observation, interview, and document review, the facility failed to provide repositioning timely for 1 of 3 residents (R4) reviewed who were at risk of developing pressure ulcers. Pleasant Manor staff have the responsibility to provide care to residen who are unable to carry out activities of daily living to promote their health, including assessment during their stay and providing care daily. The policy named Repositioning was reviewed and remains appropriate. R4' repositioning plan of care was reviewed and remains appropriate. R4's skin has been reviewed and remains free of skir alterations. All resident's repositioning plans of care have been reviewed, discussed at IDT, and repositioning plan of care remain appropriate. All nursing staff will be educated on the	e ts ?s l s n ns

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245090	B. WING				C 28/2020	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
			27 BRAND AVENUE					
PLEASA	NT MANOR LLC			F	ARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	and daily use of AS [blood thinner]. She bladder. Resident n over skin tear on LL otherwise intact. Pr place with toileting a hours, pressure rec wheelchair and mat cares q [every] AM weekly skin inspect R4's care plan date alteration in skin int "Monitor skin integr inspection by nurse order. Pressure red Pressure redistribut chair." Care plan im R4's care plan furth mobility related to e "Dependent with be staff]. Maxi lift (Hoy transfers. Turn and hours]." Additionally "Alteration in comfo 9/8/20: "Position q2 [as needed] with pil R4's nursing assista "Assist of 2 w/ [with not ambulate." The on how often to ass repositioning. A Hospice Facility V 9/3/20 included, "Do to bottom."	A [aspirin] and Coumadin e is incontinent of bowel and noted to have scabbed area LE [lower left extremity]. Skin eventative skin measures in and repositioning q [every] 2 distribution cushion to ttress to bed, routine skin [morning] and HS [night], and ions." d 6/26/20 included, "Potential egrity." Staff were directed to, ity daily. Weekly skin e. Treatment to open areas per listribution mattress to bed. tion cushion to wheelchair, terventions updated 9/1/20. her indicated, "Alteration in end of life" with interventions: ed mobility: A1-2 [assist of 1-2 er) [mechanical lift] with reposition Q2H [every 2 / R4's care plan specified, ort," with an intervention dated thrs [every 2 hours] and PRN	F 6	86	repositioning policy. DON or designee will perform audit weekly x 4 weeks, monthly x 3 mor and quarterly thereafter to ensure compliance. Audit results will be re- monthly at QAPI meetings for further recommendations. Completed 11/2/2020	nths, viewed		

		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING	i			C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	starting at 10:25 a.r herself in the wheel effectively adjust he members asked R4 R4 verbally decliner offered to recline R4 declined. No encour provided. No additio occurred. At 11:46 at (LPN)-D brought R4 sugar and administ repositioned. LPN-I room. At 1:55 p.m. NA-B assisted R4 in bed using 2 pillows stated, "Oh God, th pain was in her bac When interviewed of and NA-B stated the morning cares at 7: not had time to ass since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge the same position in repositioned. R4 sh hours. When interviewed of director of nursing (repositioned every 3 The facility policy R 5/2013) identified, " resident who is imm	m. R4 was attempting to adjust lchair, but was not able to erself. At 10:34 a.m. 2 staff 4 if she would like to lay down. d. The 2 staff members 4's wheelchair. R4 verbally tragement or re-approach was onal attempts to reposition a.m. licensed practical nurse 4 to her room to check blood er insulin. R4 was not D brought R4 to the dining nursing assistant (NA)-F and nto bed and positioned her in . As R4 was laid in bed she at hurts." R4 specified that the tk. on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or reposition o at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours in n her chair without being hould be repositioned every 2	F	586			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE CONSTRUCTION		E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		PLETED
		245090	B. WING			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		20/2020
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 686	"Residents who are every 1 hour (q1 ho Residents who are an every 2 hour (q2 schedule." Facility p Wound Manageme	in a chair should be on an our) repositioning schedule. in bed should be on at least hour) repositioning policy Skin Assessment and nt (revision date 7/2018) skin inspection will be	F 6	86		
	Free of Accident Ha CFR(s): 483.25(d)(§483.25(d) Acciden The facility must en §483.25(d)(1) The	azards/Supervision/Devices 1)(2) nts.	F 6	89		10/1/20
	supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility f assess 3 of 5 resic had fallen, and imp prevent further falls for R1 when she su and fractured her s failed to ensure 2 o reviewed for chokin ordered modified te Findings include: R1's quarterly Minin 8/20/20, included, s with diagnoses includes	resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview and document ailed to comprehensively lents (R1, R4, and R3) who lement interventions to 5. This resulted in actual harm istained 19 falls, broke a finger kull. In addition, the facility f 5 residents (R10 and R5) bg risk were served the exture diet.		F689=G. Based on observation interview, and document review facility failed to comprehensive of 5 residents (R1, R4, and R3 fallen, and implement intervent prevent further falls. This resu actual harm for R1 when she s falls, broke a finger and fractur skull. In addition, the facility fa ensure 2 of 5 residents (R10 a reviewed for choking risk were ordered modified texture diet. Pleasant Manor ensures that th residents' environments remai as free of accident hazards as The facility identifies each reside for accidents and develops a p	v, the ly assess 3) who had ions to lted in ustained 19 ed her iled to nd R5) served the n safe and possible. dent at risk	

Facility ID: 00568

If continuation sheet Page 13 of 61

TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
			A. BUILDING	3		C
		245090	B. WING		09/2	28/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	ge 13	F 689			
	assistance with mo (ADL's) and did not falls with injury since had a discharge MI R1's falls Care Area included, "Resident having impaired ba medication use. Re following hospitalization infection] and incre- involved in a MVA [November and suff including but not lim rib fractures, and w increased risk for fa agitation, and daily anticonvulsant, ant benzodiazepine me of bowel and bladd history of falls prior any falls since adm to a room closer to Plan to continue to light in reach, and f recommendations.' would be addressed R1's admission Fal 5/19/20, included a falls as identified in there was no analy identification of inter reduce the chance R1's care plan date	st activities of daily living ambulate. R4 had 2 or more be the prior assessment. R1 DS dated 9/16/20. A Assessment dated 5/22/20, t triggers for falls r/t [related to] lance and daily psychotropic esident has decreased mobility ation for a UTI [urinary tract ased behaviors. Resident was motor vehicle accident] last fered multiple major injuries hited to: skull fractures, TBI, rist fractures." "Resident is at alls r/t cognitive impairment, use of psychotropic, ihypertensive, and edications. She is incontinent er. She does not have a to admission and has not had ission. Resident was moved the nurses station for safety. monitor for safety, keep call follow therapy ' The CAA indicated falls d in the care plan. I Review Evaluation dated check list of risk factors for the 5/22/20 CAA. However, sis of fall risk factors or erventions that may mitigate or		addressing safety issues and im procedures to prevent accidents incidents. The policy related to assessment have been reviewed and remain appropriate. The policy related to modified textured diets has been and remain appropriate. R4 and R3's incidents have been reviewed, assessed, and plan of updated. R1 has been discharg the facility. All resident's incident been reviewed, assessed, and p care updated appropriately. All n diet textures plans of care have reviewed and remain appropriate Nurses were educated on post fi- evaluation process and IDT was on the process of incident review analysis and expectations regard timely completion. Culinary staffi educated on proper service of m textured diets Administrator/DON or designee perform audits weekly x 4 weeks x 3 months, and quarterly therea ensure compliance. Audit results reviewed monthly at QAPI meetifurther recommendations. Completed 10/1/2020	and t of falls o reviewed n care ed from ts have lan of resident's been e. all educated v and ding f were odified will s, monthly fter to s will be	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245090	B. WING			(09/2	_ 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	disturbances." The "Resident will be sa should incident occ use one assist for the Place bed on low pro- both sides of bed. unless providing ca chair for comfort. T in wheel chair. Pro- taking outside and w R1's Action Summa identified R1 had fa 7/31/20, 8/1/20, 8/5 8/12/20, 8/16/20, 8/ 8/21/20, 8/29/20, 9/ addition, R1's progr 8/30/20 identified sl not included on the no progress notes as to mat next to the bed 8/5/20, 8/6/20, 8/16 times, 8/29/20, 8/30 identified from a wh 9/15/20. 1 fall from was no documentat circumstances of the 7/14/20. R1's Incident Revie included, R1 was for Incident Analysis in resident's room and	ge 14 goal for R1 was listed as, fe and free from serious injury ur." Staff were directed to, ransfers with a standing lift. osition. Have fall mats on Leave door open at all times res. Use a tilt-in-space wheel o be visually supervised when vide one on one care, such as wheeling her down the hall. ary dated 7/1/20 to 9/28/20, llen 17 times on 7/14/20, /20, 8/6/20, 8/11/20, 8/12/20, 16/20, 8/16/20, 8/19/20, 3/20, 9/14/20 and 9/15/20. In ess notes dated 7/29/20 and he had fallen, but these were Action Summary. There were or incident reports for the falls tion Summary which were /20 (2 falls), 8/19/20, or the falls were identified in the being a fall from bed onto the . These were on 7/31/20, /20 - three times, 8/21/20-3 0/20, and 9/3/20. 2 falls were beel chair on 8/29/20 and recliner on 7/29/20. There tion to determine the the falls that occurred on 11/20, 8/12/20, 8/19/20 or	F	589			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING	i			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	which contributes to diagnosis of unspect consciousness; Der disturbance." The f listed: proper footw (physical therapy/od lowest position and to be visually super Provide tilt-in-space recline resident whe comfort. Staff provis such as taking her of down the hall. "Res times heard yelling, attention to staff and reassurance. Resid lack of safety aware dementia. Residen and restlessness ar resident's self trans to tend to her." The to the care plan. R1's progress note [certified nursing as [10:00 a.m.] that res chair. Upon entering sitting on the footrear recliner was tilting for resident back to sea R1's progress note 8:40 PM writer hear room and found res to her bed." Abrasic There was no asses Interventions addeor	b resident's fall risks due to cified TBI w/o loss of mentia with behavioral follow-up/intervention section vear, evaluation by PT/OT coupational therapy), bed in soft touch call light. Resident vised when in wheelchair. wheelchair with the ability to en in chair to provide ore iding 1:1 (one on one) care butside and wheeling her sident with behaviors and often Resident requires 1:1 d to redirect and provide dent is at high fall risk due to eness due to TBI and t also experiences agitation nd could be the reason of ferring to get staff's attention ese interventions were added dated 7/29/20, included, "CNA sistant] told writer at 1000 sident had slid forward in her or groom writer found resident st of her recliner and the orward. Three staff assisted at [sic] of the chair." dated 7/31/20, included, "At rd resident calling out from her sident on the floor laying next ons were noted to both knees.	F	689			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	room is dark was no R1's Incident Revie 8/5/20, identified R2 7/31/20. The repor- out of room." No fu- was documented. If of notifying the nurse anxiety, agitation, re- change in medication restlessness, and a R1's Incident Revie 8/5/20, identified R2 on 8/1/20. The form to get out of room." intervention as the 8 7/31/20. There was regarding this fall. R1's progress note "Resident found on out. Asked her wha going to the floor." this. R1's progress note included, "Writer no medication aide] at was on the floor." F bed. The note indio notified due to incre antianxiety medicat she hurt all over. R1's progress note	ge 16 bathroom light on when the ot added to the care plan. w and Analysis report dated 1 was found on the floor on t identified R1 wanted to, "get inther assessment of this fall However, a new interventions se practitioner of, "frequent estlessness and request a ons to decrease anxiety, igitation," was requested. w and Analysis report dated 1 had been found on the floor n identified, "Resident wanting This listed the same 8/5/20 report for the fall on s no assessment completed dated 8/6/20, included, floor by bed on knees. yelling t she was doing and she said There was no assessment of dated 8/16/20, at 3:46 p.m. otified by TMA [trained 1500 [3:00 p.m.] that resident R1 was sitting on floor mat by cated the physician was then eased anxiety and additional ion was ordered. R1 indicated dated 8/16/20, at 10:28 p.m. d writer into room. Resident	F	589			
		d writer into room. Resident nd and torso was still in the					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	facility." R1's progress note included, "Aid called sitting on floor with was wanting to leav R1's progress note included, "Resident bed. Resident had slid out of her bed. leave facility and ca me out of here." R1's progress note "Writer observed re mat next to bed this at lowest position happened and reside of here." R1's progress note 2:15 PM writer hear Writer found reside her W/C [wheel cha Writer found 1" [inc forehead. Resident footwear, foot peda incontinence noted. to writer what happe my head." Cool we forehead. Then fou	confused and wanted to leave dated 8/16/20, at 10:35 p.m. d nurse in to find resident arms on the bed. Resident	F	689	· · ·		
	"Writer heard repeat room and found res	dated 8/30/20, included, ated yelling out from resident's sident on the floor next to her west position, call light within					

Facility ID: 00568

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 689	Continued From pareach, fall mats in president not incontine R1's progress note on right index finge. There was no incide determine when the R1's progress note physician had been index finger. R1's progress note sore right finger." R1's treatment recommitter right index However, it did not injury. R1's progress note "Writer heard reside when writer arrived floor next to her been up. Bed was in low place and call light Even though R1 had there was no comp determine the reaso any pattern in time of the determine why the working to prevent the rest of the solution of the	age 18 blace both sides of bed, and nent." dated 8/30/20, noted a bruise r and a scrape on her head. ent report or assessment to ese injuries occurred. dated 8/31/20, included, the updated on bruise to right dated 9/2/20, included, "Ice to ord identified staff were to finger related to a fall. identify which fall caused this dated 9/3/20, included, ent yelling from her room and resident was sitting on the d yelling, "Help me get back vest position with fall mats in in reach." d fallen from bed 13 times, rehensive assessment to on R1 was falling from bed, of day or situation, or to current interventions were not further falls. dated 9/10/20, included, a finger related to a fall." "Nail	1	589		RATE	DATE
		dated 9//13/20, identified to,					

Facility ID: 00568

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING	i			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	"Monitor right index "Patients finger com nail bed no redness remains intact at thi R1's Incident Revie 9/15/20, identified F wheelchair on 9/15/ cause of R1's fall fm The form identified emergency room for wound. R1's hospital Admis dated 9/15/20, inclu floor in bedroom an herself on floor at n agitated/verbally up upstairs." The rest an acute nondisplat posterial parietal bot hospital discharge s sustained a closed her right hand 2nd f before returning to fracture was in a sta had happened in th an injury to R1's rig progress notes on 8 not assessed by a p hospitalized on 9/15 When interviewed of stated R1 had faller wheel chair, she wa and required one or fall. NA-B stated th on ones with R1. N	finger related to a fall." tinues to be black around the or warmth noted to site. Nail is time." w and Analysis report dated A1 had fallen from her '20. No assessment of the om the chair was completed. R1 was sent to the r evaluation due to a head sion History and Physical ided, "Patient was found on d then seemed to throw ursing station. She has been set at times. Wanting to go ults from a CT of head noted ced fracture of the left one (skull fracture). R1's summary identified R1 had skull fracture and a fracture of finger which would be splinted the nursing home. The finger age of healing, identifying it e past. The facility identified ht index finger in the the 8/30/20. However, this was obysician or x-rayed until	F	589			

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	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
	245090	B. WING	;			C 28/2020
NAME OF PROVIDER OR SUPPLI	ĒR			STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASANT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
sit with her one of as other residen When interviewe stated R1 had fa scream and thro interventions sho the low position R1 did this she w remembered R1 area on her fore but did not know When interviewe guardian stated sustaining a frac undiagnosed for When interviewe licensed practica constantly throw threatening to th was not enough supervision with any assessment determine why s was R1's behavit assessment of F she was, "throwith When interviewe director of nursin a good system fa are trying to imp	and up all the time, other than to on one, winch was not possible ts required care too. and on 9/24/20, at 1:31 p.m. NA-C illen frequently, she would w herself from bed. The only e knew of was to have the bed in and mats on the floor so when vouldn't be injured. NA-C had a large swollen egg sized head and had broken her finger, when this occurred. and on 9/24/20, at 3:07 p.m. R1's they were concerned about R1 stured finger that went		689			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	after each fall. The of these for R1's fal sustained on 7/14/2 9/15/20. The DON assessment had no other falls R1 susta issues and really re which they were un was unable to provi determine if there v what interventions r anxiety/behaviors the frequently. No assessment	age 21 e DON was only able to find 4 lls, which were for the falls 20, 7/31/20, 8/1/20, and did not know why this ot been filled out for any of the ained. R1 had behavioral equired one on one attention, table to provided. The DON ide any assessment to was a pattern to R1's falls, and may assist R1 with her hat led to her falling so essment had been completed to determine interventions that	F6	589	}		
	included severe cog diagnosis of demen disturbance. R4 rec mobility and dressin for transfer, toileting was totally incontine cares 1-3 times dur R3 had 1 fall withou assessment. R4's fall CAA includ r/t having impaired psychotropic medic declined in both mo She has recently er	quired extensive assist for bed ng and total staff assistance g, and personal hygiene. R4 ent of bladder and rejected ring the assessment period.					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATI COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	of hypoglycemic, ar narcotic, and psych incontinent of bowe recent fall from bed for safety and keep R4's care plan date related to [blank]. S lowest position. Cal Follow PT and OT i function." The most "Ambulate to dining walker] support with 120 ft [feet] x1 [with was added 7/22/20 been made. R4's nursing assista "Assist of 2 w/ [with not ambulate; fall m R4's progress note included, "At 7:35 p lying on floor next to agitated/anxious an stand/yell at staff. F when trying to posit sling so resident as Ax2 [assist of 2 staf fall mat was in plac lowest position; roo lit." "Resident receiv Seroquel [antipsych agitation/anxiety an following hour. Hos of nursing], and em notified. Writer and about in-facility fam	ant Care Sheet included, or ordinal updates had ant Care Sheet included, Hoyer [mechanical lift] sisted 8/26/20, at 10:51 p.m. murse aide found resident obed. Resident appeared to bed. Resident appeared	F	\$89			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	contact thought it w Emergency contact visit tomorrow." When interviewed of registered nurse (R incident report or po fall. R4's care plan R4, as she is no lor When interviewed of family member (FM allowed to visit relat concerned about R- would not be able to a visit. No one had possibly visiting to of When interviewed of LPN-D stated R4 has rolling from bed. Th to the bed and mak reach. LPN-D state use the call light an intervention. When interviewed of stated, R4 was to h visits after this fall to The DON stated, th meet after each fall plan, and communi increased family vis communicated to th plans. R3's admission MD	on 9/28/20, at 10:00 a.m. N)-A stated there was no ost fall follow-up report on R4's was incorrect about walking nger able to ambulate. on 9/28/20, at 11:35 a.m. I)-B stated they had not been ted to COVID and was 4's falls. FM-B stated R4 o see them out her window for spoken to them about decrease anxiety. on 9/28/20, at 12:35 p.m. ad fallen a couple times, hey put a mat on the floor next e sure R4 has her call light in ed R4 would not know how to d was unsure why that was an on 9/28/20, at 3:05 p.m. RN-A ave increased family window o aide in preventing more falls. the interdisciplinary team should , update care sheets and care cate the change, but the	Fθ	\$89			

Facility ID: 00568

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CENTERS FOR MEDICARE & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
245090 B. WING	C 09/28/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, C	CITY, STATE, ZIP CODE
PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR	ER'S PLAN OF CORRECTION (X5) RRECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DATE DEFICIENCY)
F 689 Continued From page 24 F 689 including a stroke and dementia. R3 required extensive staff assistance with most activities of daily living (ADL's), was unsteady, had a history of falls prior to admission and had fallen since admission with no injury. R3 did not have delusions or hallucinations. R3's falls CAA dated 8/19/20, included, "Resident triggers for falls r/t having impaired balance, history of falls, and daily antidepressant use. Resident has had a recent decline in mobility following hospitalization for increased overall weakness. He had a CVA [stroke] and has increased right side weakness. He is in PT and OT at this time with the goal of returning to the community. Resident is at increased right of falls r/t daily antihypertensive, psychotropic, diuretic, and hypoglycemic medications. He is incontinent of bowel and bladder. He has impaired cognitive, vision, and hearing. Resident does have a history of falls prior to admission and has had one fall since admission where he was reaching for something on the floor. Plan to continue to monitor for safety, keep call light in reach, and follow therapy recommendations. Care planning would be completed. R3's Fall Review Evaluation dated 8/15/20, included a checklist of risk factors including fall before admission, fall after admission, medication use that can increase falls, cognition and sensory deficits, incontinence, confined to chair, and concerns with balance. There was no analysis of findings or indication on how any of these risk factors would be addressed. R3's care plan dated 8/12/20, included, "Fall risk related to lack of safety awareness secondary to dementia." R3's goal was, "Resident will be safe	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245090			B. WING			C 09/28/2020	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	and free from falls.' Answer call light pro for transfers, follow in reach, proper foc items were in reach R3's progress note included, "Writer wa walked in and saw floor. Resident was eating supper. Aid, resident up using he Resident states tha dropped and he we his wheelchair. Res on the chair that wa R3's progress note included, "Resident was at the medicine "Pt [patient] was att RN heard some sou his wheel chair and saw the resident fal R3's progress note "Writer was called to floor. Resident wa and had his hands Resident was sitting sitting up. Resident was for all transfers." R3's progress note	 Staff were directed to, omptly, use a mechanical lift therapy instructions, call light of therapy instructions, call light of therapy instructions, call light of the approximation of the second structure of the se	F	\$89			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING	;			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	"Resident was layin Resident was holdin waiving it in the air. right next to him wit Resident states he his room and using out of his way. Res wheelchair while do there were no cats assessment of R3's room, even though or delusions at the assessment. When interviewed of LPN-C stated other care plan, no new in any of these falls. I any post fall assess The facility had not determine root caus prevent the falls fro increased confusion not assessed other which the family de- interdisciplinary tea next day and place that assessment, bu R3. When interviewed of	ed. dated 9/11/20, included, g on back on the ground. ng handle gripper in hand and Residents wheelchair was h the breaks unlocked. was chasing the cats out of the handle gripper to get them ident then fell out of ing this." "Resident was told in this facility." There was no a belief there were cats in his R3 had not had hallucinations time of the comprehensive on 9/28/20, at 10:31 a.m. than what was already in the nerventions were added after _PN-C was unable to provide ment for any of these falls. assessed each fall to se, nor place interventions to m happening again. R3 had n after admission, which was than to offer psych services, clined. Normally, the m would assess each fall the new interventions based upon ut this had not been done for	F	688			
	to provide the docu resident's who had facilities, "Risk man	ted the facility was not willing mentation related to any of the fallen as it is part of the agement." They were unable mentation that R1, R4, or					

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		AND HUMAN SERVICES				FORM	: 11/02/2020 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DAT COM	E SURVEY
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	R3's falls had ever l assessed to determ prevent further falls A facility policy titled Management, revis procedure for staff a a fall, "staff will mor resident's response intervention put in p 72 hours post fall. 2 staff will re-evaluate appropriate to conti interventions. As ne provider will assist n not previously ident documented that fa will implement appr prevent serious inju- be updated to reflect R10's quarterly MD cognitively intact wi lung disease. R10 up assistance with R10's Speech Ther included a diagnosi dysphagia (difficulty throat) and oral pha in the mouth). The risk for aspiration of Recommendations consistency, small b (chewing), swallow bite/sip, slow pacing between liquids/soli	been comprehensively ine interventions that may from occurring. d, Fall Prevention and ed 2/2020, indicated follow-up after a resident had sustained hitor and document the to and the effectiveness of place to prevent further falls for 2. If resident continues to fall, the situation and whether it's nue or change the current eded, the resident's medical reconsider possible causes ified. 5. If it is determined and lls may be unavoidable, staff opriate interventions to ury from falls. 6. Care plans will ct fall interventions." S dated 7/14/20, included th diagnoses of diabetes and required supervision and set eating. apy evaluation dated 3/26/20, s of pharyngeal phase / swallowing for issues in the ase dysphagia (due to issues evaluation noted R10 was at	F	\$89			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMEN	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245090			B. WING			C 09/28/2020	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	R10 would be appro R10's nutritional sta identified a risk fact diet. No analysis of completed. R10's care plan dat nutritional alteration meals; had diet res [National Dysphagia ground or are minor pieces, they are mo and could have req directed to monitor, physician as neede swallowing problem R10's undated nurs included mechanica R10's Nutrition Eva identified a mechan meat. Speech ther all meats ground, u for preference." R10's Oral/Dental E indicated R10 had f During observation was observed to be 12:47 p.m. it was no hamburger patty on hard to eat because dentures in. She ha as the staff had grill desired one. R10 of	opriate for diet upgrade. atus CAA dated 4/10/20, tor of a mechanically altered f this risk factor was ted 4/1/20, included, risk for n related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be ed no larger than 1/4 inch bist, with some cohesion] diet uested puree. Staff were document, and report to the d for signs and symptoms of	F 6	89			

Facility ID: 00568

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/02/2020 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ì í			(X3) DATE SURVEY COMPLETED		
		245090	B. WING			C 09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	nor did anyone brin R10's lunch tray ticl texture and to provi potato salad, no ray lettuce." When interviewed o aide (DA)-A stated	-	F	689			
	with ground meat. she normally does with When interviewed of (CK)-A stated, a mean ground meat, no bric cook is the person of correct diet is served When interviewed of stated R10 does con unaware R10 did no stated if someone is should go get a nur in the dining room. When interviewed of	R10 coughing is something while eating. on 9/25/20, at 1:12 p.m. cook echanical soft diet should have ead or hard vegetables. The responsible to ensure the					
	today got a regular grilling them. R10 s dentures, but forgot have to remind her them. At 1:39 p.m. asked her if she wa When interviewed o stated resident's die wished for an upgra	whole burger as they were stated she normally wore her t them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H					

Facility ID: 00568

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		AND HUMAN SERVICES				FORM	: 11/02/2020 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				7 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	a risk versus benef she given the risks a regular hamburge When interviewed of Cook-A stated they who had signed a r for a diet upgrade, f they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Gr consistency and pa pureed food if desir When interviewed of registered dietician coughing during a r the DON, food serv therapy. This had r facility should not p diet without risks be and a form signed. When interviewed of	its statement signed nor was of choking when provided with er today. on 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the s ordered and not a regular ion Form provided by Cook-A had been completed by d indicated R10 was to have a ound Meat NDD2 diet tient could downgrade to red. on 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to rice director and speech not been done for R10. The rovide an upgraded texture eing explained to the resident on 9/28/20, at 2:37 p.m. the	F	689			
	the correct diet text swallowing problem if a resident is coug R5's quarterly MDS	ted it is important to provide ure for residents with is. A nurse should be notified hing. 6 dated 9/4/20, indicated no nt with diagnoses including,					
		he MDS noted R5 had					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245090	B. WING			(09/2	28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	coughing and choki swallowing medicat	ge 31 ing during meals or when tions during the assessment urther indicated supervision,	F6	89			
	•	en eating and mechanically					
	indicated diagnoses and oral phase dysp indicated R5 had m the evaluation had f dentures that did no without dentures, R consistency solids a Advanced. R5 was of materials into the penetration (passag and/or asphyxiation						
	dated 1/20/20, indic mechanically altered	nent Area Worksheet (CAA) cated R5 required a od diet. There was no analysis noted to proceed to care					
	risk for nutritional al pain front thorax an diet. Staff were dire	ed 3/20/20, indicated R5 was at Iteration related to chronic ad diet restriction for NDD3 ected to monitor, document cian for signs or symptoms of ting.					
		dated, 1/25/19, indicated her o NDD3 by Speech therapy.					
		aluation dated 9/4/20, identified D3, Dysphagia Advanced diet					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	R5's Care guide for and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticko Dysphagia Advance further directed to p hamburger on bun, vegetables, backed lettuce, soft ice creat During an observat R5 sat alone at a tak while she ate her m whole hamburger w covered the burger There were various area including nurs stopped to see why p.m. R5 was observ for someone get a having a seizure. S of the dining room. When interviewed of stated R5 should have beans, potato salad should not have ha have been ground a potato chips or who When interviewed of stated she has occa "spells," and has no	 staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, d care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw l beans, no bacon, shredded am and milk. ion on 9/25/20, at 12:50 p.m. able and was noted to cough real. R5's plate contained a <i>vi</i>th a wedge of lettuce that on a bun and potato chips. staff throughout the dining ing and dietary, but no one R5 was coughing. At 12:52 wed to be shaking and asked nurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A ave received ground meat, d, soft cooked vegetables. R5 d a bun, the burger should and should not have received ble leaf lettuce. on 9/25/20, at 1:10 p.m. R5 asional seizure that are like, 	F 6	89			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATI COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				7 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	have ground meat, For the noon meal mechanical texture ground hamburger, was the cook's resp resident is getting the When interviewed of stated staff should coughing and should have received the of who gave her the w When interviewed of Dietary Aide-A repo- aides deliver meal the When interviewed of stated a resident is upgraded texture if been signed. The re- order from the physic and benefit form. R On 9/25/20 at 3:08 should have received not, the Cook is resp correct diet. The facility Refusal and Benefits policy resident would be in benefits of necessar opportunity regardin care. The resident of times and if resident	no bread or hard vegetables. provided on 9/25/20, a should have included, no bun, potato salad and beans. It ponsibility to make sure a ne appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ld get a nurse. R5 should correct diet and did not know rrong diet. on 9/25/20, at 1:40 p.m. rted both dietary and nursing	F	\$89			

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		AND HUMAN SERVICES				FORM	: 11/02/2020 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING	i			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			ļ	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 34	F6	689)		
F 725 SS=F	Dysphagia Mechan Level 1 are allowed foods may be grour no larger than one f should be easy to c Moistened ground of fish. Moist ground of with gravy or sauce pureed bread mixes and slurred breads thickness of produce vegetables. Vegetable vegetables. Vegetable Sufficient Nursing S		F 7	725	5		11/2/20
	the appropriate com provide nursing and resident safety and practicable physical well-being of each r resident assessment and considering the diagnoses of the fact accordance with the at §483.70(e). §483.35(a)(1) The f by sufficient number types of personnel of nursing care to all r resident care plans	Ave sufficient nursing staff with inpetencies and skills sets to d related services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care e number, acuity and cility's resident population in e facility assessment required facility must provide services ers of each of the following on a 24-hour basis to provide esidents in accordance with					

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		& MEDICAID SERVICES	(X2) MUI TI			0938-039		
	F CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED		
						2		
		245090	B. WING		09/2	28/2020		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE		
F 725	Continued From pa	ige 35	F 72	25				
	this section, license (ii) Other nursing pe limited to nurse aid	ersonnel, including but not						
	paragraph (e) of thi designate a license nurse on each tour This REQUIREMEN by:	NT is not met as evidenced						
	review, the facility f staffing to provide f planned needs for 8 R1, R3, R8, R13 ar LPN-A, LPN-D, NA NA-A, RN-A, HSK- members (FM)-A,	tion, interview and document ailed to ensure sufficient for the individualized care 8 of 8 residents (R5, R7, R4, nd R12), 12 of 15 staff (LPN-B, -D, NA-C, NA-J, NA-B, NA-F, A and NA-C) and 1 of 3 family reviewed for sufficient staffing. tial to affect all 42 current		 F725=F. Based on observation, in and document review, the facility fa ensure sufficient staff to provide fo individualized care planned needs 8 residents, 12 of 15 staff, and 1 or family members, reviewed for suffi staff. This has the potential to affer current residents. Pleasant Manor has the responsib provide services by sufficient numbers and dignity promote resident rights and dignity 	ailed to r the for 8 of f 3 cient ct all 42 ility to pers to			
	Findings include:			The policy in regards to completing Facility Assessment has been revio	ga			
	included cognitively stroke with paralysi the body and a seiz	num Data Set dated 9/4/20, / intact with diagnoses of s or weakness on one side of cure disorder. R5 required from staff for toileting and		and remains appropriate. The facility completed a facility assessment to assess and identify appropriate staffing needs for the of level of care and provide guidance future staffing needs for the appropriate staffing needs for the appropriate staffing needs for the appropriate staffing assignt	current for priate			
	1/20/20, included, activities of daily liv and toileting.	ent Worksheet (CAA) dated R5 extensive assistance with ing (ADL) including bathing		 will be signed off by Administrator of Director of Nursing daily. Education will be completed with II through QAPI and with facility staff through an all-staff meeting regard 	or OT ling			
	needed assistance shower/bath with or	ated 8/12/20, included, R5 with toilet use and ne assist twice a week on esday evenings with skin		 executed facility assessment and or review of staffing. Administrator or designee will perform audits weekly x 4 weeks, monthly x 	orm			

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							0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION		E SURVEY PLETED	
							C	
		245090	B. WING				28/2020	
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE	
F 725	Continued From pa	age 36	F 7	25				
	checks.				months, and quarterly thereafter to			
	licensed practical n not getting the time toileting, bathing ar	on 9/24/20, at 12:23 p.m. hurse (LPN)-A stated, R5 was ely care she needed with nd hygiene as there was not id complain about this.			compliance. Audit results will be re monthly at QAPI meetings for furth recommendations. Completed: 11/2/2020			
	When interviewed on 9/24/20, at 2: 20 p.m. R5 stated, "This facility is very short staffed. I wait over an hour to get an answer to my call light." R5 stated it takes a long time to get help to go to the bathroom, and, "I should have a bath every Sunday and a shower every Wednesday. The aid would rather I just take a shower because it takes less time and effort. Sometime, I get neither because they say there are not enough aids on." This was upsetting to R5.							
	nursing assistant (I assistance with bat she had to wait for have enough staff	on 9/24/20, at 3:22 p.m. a NA)-D stated R5 required hing and toileting, but often assistance as they do not to get to everyone timely. ave to skip R5's bath as they h time.						
	licensed practical n complained of not g	on 9/24/20, at 3:45 p.m. a Jurse (LPN)-B stated, R5 getting her shower on a regular setting to her, but they were could.						
	not receive a bath of stated, "R5's showe evening due to time did not get done du	ncern Report included, R5 did or shower on 7/22/20. NA-I er did not get done on Sunday e." NA-J stated, "R5's shower ie to running out of time. Her ids which [NA-I] and I were the						

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	only two on the floo had a lot to do and time to get in the ba another shower that that we never got d Shower/bath record 2020: R5 received again until 8/17/20, 8/24//20. R5 received again until 9/21/20. Review of R5's cal p.m.) to 9/29/20 (2: the call light 166 tim wait time was over 41.5% of the time. R7's admission MD moderate cognitive of a stroke. R7 was required assistance transfer on and off R7's ADL (activities Rehab Care Assess dated 9/25/20, includecline in mobility, of bowel and bladdet toileting upon reque R7's care plan date required assistance dependent assist, o personal hygiene se occasionally inconti with toilet use."	ar until 6 p.m. After 6 we still ended up not having enough ath R5 wanted. There was also t was supposed to get done one." ds dated July to September a shower on 7/19 but not and then not again until ed a bath on 9/13/20, but not I light log from 9/1/20 (6:53 24 p.m.), indicated, R5 used nes. Of the 166 instances, the 20 minutes on 69 occasions or eS dated 7/28/20, included impairment with a diagnosis a occasionally incontinent and by one staff person to of the toilet. of daily living)/Functional sment Area Worksheet (CAA) uded, R7 has had a recent was occasionally incontinent er, and needed assistance for	F 7	725			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	week she found R7 when she started he was not enough stat hygiene needs in a When Interviewed of was lying in bed. R7 facility is very bad. If there seems to be r facility. Call lights ca hour. I push the call bathroom and no or wet myself. I feel h chair and embarrass cleaned up and cha brow was furled and R7 stated this happ When interviewed of nursing assistant (N wait for assistance her incontinent. Thi Most residents wait time to receive an a has assisted R7 aft secondary to waitin time for the call ligh that there have bee beginning of the shi soiled and need ass night shift is custom one licensed practic	IA)-C reported the previous soiled halfway up her back er shift. NA-C reported there iff to meet R7's toileting and	F	725	5		
	LPN-D stated there	on 9/25/20, at 2:55 p.m. was insufficient staff to meet s of each resident. The					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PLEASA	NT MANOR LLC				7 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725		•	F	725			
	morale among staff of this.	f and residents is low because					
	9/22/20, at 3:51 a.m showed the call ligh the seven day perio initiated, 11 (or 21.5 15 minutes to receive	onse time logs dated from n. to 9/28/20, 9:25 a.m. nt was engaged 51 times over od. Of the 51 call light alerts 5%) of these alerts took over ve a response. Seven (or s took longer than 20 minutes ise.					
	6/29/20, included, n with diagnoses inclu arthritis. R4 require toileting and limited hygiene. R4 was no	nimum Data Set (MDS) dated moderate cognitive impairment uding diabetes, dementia and ed extensive assistance with assistance with personal ot on a toileting program and continent of urine (less than 7 sessment period).					
	dated 7/1/20 indicat urinary incontinence assistance with tolk incontinence." "She and OT [occupation the goal of returning uses incontinence p dry. Plan to continu and complete period	Care Area Assessment (CAA) ted, "Resident triggers for e r/t [related to] need for et use and bladder e is in PT [physical therapy] nal therapy] at this time with g to the community. Resident products to aid in keeping skin e to with current toileting plan cares q [every] AM [morning], n each incontinent episode."					
	included severe cog dependent upon sta hygiene and was al	inge MDS dated 8/27/20, gnitive impairment, was totally aff for toileting and personal ways incontinent of urine.					
	R4's incontinence C	CAA dated 8/28/20 included,					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	 "Resident triggers fit toilet use and bladd declined in both more She has recently error life cares. Resident aid in keeping skin current toileting plan [every] AM [morning incontinent episode R4's only Bowel and medical record was R4 was continent or R4's care plan date "Alteration with elimit to, "Assist of 1 with not been updated s 8/27/20, MDS noted incontinence to total in assistance needs hygiene. R4's nursing assistation assistants of 2 w/ Hoye ambulate." No informursing assistants of toileting needs. During continuous of starting at 10:34 a.m. if she would like to be declined. No encou provided. No addition incontinence cares licensed practical n her room to check be insulin. LPN-D then 	or urinary incontinence r/t der incontinence. Resident has obility and cognitive function. nrolled in hospice for end of uses incontinence products to dry. Plan to continue to with n and complete peri cares q g], HS [night], and with each	F 7	225			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	1:58 p.m. NA-F and and changed R4's w When interviewed of and NA-B stated the morning cares at 7: not had time to ass since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge without being assist When interviewed of director of nursing (should be assisted hours. The DON st needs very well. Re was present review and Bladder assess 6/24/20, noting it in bladder. RN-A revie identified R4 had no Bladder assessmen significant decline in June of 2020. RN-A an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least ew R4's call light log fro R4 used the call ligh instances the wait t	A NA-B assisted R4 into bed visibly wet brief. on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or toilet of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. on 9/28/20, at 3:05 p.m. the DON) stated, she thought R4 with incontinent cares every 2 tated she did not know R4's egistered nurse (RN)-A who ved R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and of had an updated Bowel and nt, even though she had a in condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4 checked for incontinence and very 2 hours. om 9/1/20 - 9/29/20 revealed ht 20 times. Of the 20 ime was over 10 minutes on r 40 minutes on one occasion,	F	725			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMF	E SURVEY PLETED
		245090	B. WING			09/2	28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 42	F 7	725			
	8/20/20, included, s with diagnoses incluinjury) and dementia assistance with most (ADL's) and did not falls with injury since had a discharge ME R1's care plan date AEB [as evidenced admission related to secondary to TBI and disturbances." The "Resident will be sa should incident occo "Provide one on one and wheeling her do The facility provideo from 7/21/20 thorou R1 had fallen in the frame. 7/14/20, 7/3 8/11/20, 8/12/20, 8/ 8/16/20, 8/19/20, 8/ 9/14/20 and 9/15/20 Hospital discharge sindicated R1 was tra 9/15/20 after sustail agitation. Summary fractured skull and the R1's progress notes revealed:	d 9/2/20, included, "Fall risk by] multiple falls since o lack of safety awareness and Dementia with behavioral goal for R1 was listed as, affe and free from serious injury ur." Staff were directed to, e care, such as taking outside own the hall." d a running list of R1's falls ugh 9/24/20, which indicated facility 17 times in that time 81/20, 8/1/20, 8/5/20, 8/6/20, 12/20, 8/16/20, 8/16/20, 21/20, 8/29/20, 9/3/20, 0. summary dated 9/16/20, ansferred to the hospital on ning a fall related to increased a details R1 incurred a					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATI COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	R1's progress note included R1 had att several times after Facility transferred started to yell out at and back. R1 repor neck and back. R1 wheelchair. Facility ratio as the facility of R1's physician was confirmed for the R hospital. R1's guard transfer situation. R1's progress note included, R1 was tr full report was given teams. The floor nu inform that R1 was safety concerns. R1's progress noted included, R1 was not marked behaviors: put herself onto the louder than her usu and 1:1, 2:2, 3:3 we remained aggressiv 911 to send R1 to e for further evaluation When interviewed of stated there were ti one attention, but th cover a unit of 30 re possible. When interviewed of	ge 43 dated 9/16/20, at 5:35 p.m. sempted to crawl out of bed returning from the hospital. R1 to her wheelchair, R1 then nd reported of pain in neck ted to facility of pain in her started to stand up from her initiated a 2 to 1 staff to R1 determined R1 was not safe. contacted and consulted and 1 to be sent back to the dian was informed of the dated, 9/16/20, at 6:24 p.m. ansferred back the hospital. A n to the police and transport arse called the hospital to returning to them due to d dated 9/16/20, at 6:28 p.m. oted to have continued swore at staff, attempted to floor, yelling and hollering ial, R1 was extremely agitated ere attempted and R1 ve towards staff. Facility called ere gency department (ED) on per physician's orders. on 9/24/20, at 1:00 p.m. NA-B mes when R1 required one on hey only had one or two staff to esidents, so this was not	F 7	725			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING			C 09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	all the time and she When interviewed o	-	F	725			
		back to the facility because nough help to watch her well					
	stated R1 required time to prevent her not have the time to NA-D stated she wo	on 9/24/20, at 3:22 p.m. NA-D a significant amount of staff from falling and they just did o stay with her all the time. orked the day shift and often er shift would find R1, "sopping nent brief.					
	stated there was no	on 9/24/20, at 3:45 p.m. LPN-B ot enough staffing to supervise afe as she required individual					
	DON stated due to could not be met at	on 9/28/20, at 10:10 a.m. the limited staffing R1's needs the facility, therefore R1 could fter her last admission to the					
	8/15/20, revealed R impairment. R3 req staff physical assist diagnosis included swallowing concern mouth when eating mouth/cheeks or re	aimum data set (MDS), dated A3 had moderate cognitive uired supervision and one cance for eating. R1's a stroke. R3 had the following us: loss of liquids/solids from or drinking, holding food in esidual food in mouth after ng during meals or when					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa swallowing medicat	•	F 7	25			
	staff, "The resident with adequate eatin all meals in the dini	updated 9/24/20, directed needs a calm, quiet meal time ng time. The resident requires ing room r/t [related to] close eceive meals until supervision					
	stated she worked of "understaffed." NA- be provided mornin especially if they red assistance with med required individual a not eat too quickly of get enough fluid. NA	on 9/24/20, at 12:56 p.m. NA-A day shift and considered it, -A reported residents waited to ag cares prior to breakfast, quired two staff and chanical lift. NA-A stated, R3 assistance for cueing him to or take too big of a bite and to A-A noted R3 often had to wait eat until they had enough staff to help him.					
	stated, R3 required make sure he ate th staff were available	on 9/24/20, at 3:22 p.m. NA-D staff to closely monitor to he amount he should. Often no to help, he would sit and look vaiting for his plate of food.					
	stated, there were s assistance in the di to figure out how to entire time due to c	on 9/24/20, at 3:45 p.m. LPN-B several residents that required ining room and it was difficult feed R3. R3 required help the shoking precautions and the entire meal time.					
	wheeled self into the wheel chair back an	on 9/25/20, at 12:21 p.m. R3 le dining room. R3 rolled his nd forth at the table, looking al was brought to him at 12:41					

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		AND HUMAN SERVICES				FORM	APPROVED
				TID			0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
			A. BUILDI	ING	3		C
	245090						28/2020
NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	NT MANOR LLC			2	27 BRAND AVENUE		
FLEASA				F	FARIBAULT, MN 55021		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE
IAG			IAG		DEFICIENCY)		
					-		
F 725	Continued From pa	ge 46	F 7	25	5		
	Continued From pa	90 -0		20	,		
	When interviewed o	on 9/25/20, at 1:21 p.m. NA-F					
		er enough staff in the dining					
		one. "On a good day, we are					
		es to assist all the residents."					
	R8's admission MD	S, dated 8/10/20, included, R8					
		ct with a diagnosis of					
		e. R8 required physical					
		f for transfers and supervision					
	and one person phy	sical assistance for toileting.					
		revised 8/24/20, directed					
		elimination r/t [related to] Assist of 1 with toileting as					
	needed for hygiene	5					
	needed for nygiene						
	When interviewed of	on 9/24/20, at 12:23 p.m.					
	LPN-A stated R8 wa	as independent with cares in					
		eded more assistance in the					
		oted R8 might not even turn					
	her call light on but	holler out for staff.					
	When interviewed	an 0/24/20 at 12:56 n m NA A					
		on 9/24/20, at 12:56 p.m. NA-A touch base," with R8 as she is					
		and staff need to help with					
		ired more assistance.					
	When interviewed of	on 9/28/20, at 10:37 a.m. R8					
		ot enough staff to help her					
		t. R8 stated she has problems					
		ecreased ability to do things					
		er Parkinson's medication was					
1	iale. Ro stated stat	ff tell her they have a half hour					

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PRINTED: 11/02/2020

		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	on each side of the but it is often over the they do not have en- time. R8 stated shows the bathroom, she do minutes to get on o her back to hurt and unable to care for he R8's medication ad dated August 2020, Carbidopa-Levodop Parkinson's disease stiffness, tremors, se control) five times of 4:00 p.m., 7:30 p.m. noted as being adm each opportunity, b not noted. When interviewed of LPN-D stated R8 w time. LPN-D stated getting her medicate R8's call light log, d included, R13 active two incidents, the re and 40 minutes. Or time was between 4 incident, the respon- minutes. R13's quarterly MD cognitively intact wi sclerosis. R13 requires a was incontinent of the	time her medication is due, hat. R8 stated staff tell her nough staff to get it to her on e does not get enough help to often has to wait 20-40 r off the toilet. This causes d she gets even more still and herself even more. ministration record (MAR), included an order for ba (a medication for treating e symptoms such as muscle spasms, and poor muscle laily; 5:55 a.m., 10:00 a.m., h. and 11:30 p.m. R8 was hinistered the medications at ut the time administered was on 9/28/20, at 10:58 a.m. ranted her medications on d R8 reported concerns with ions on time in the evening. ated 9/8/20 through 9/25/20, ated her call light 12 times. On esponse time was between 30 n two incidents the response 40 and 50 minutes. On one has time was over 100 S dated 9/18/20, included th a diagnosis of multiple uired two staff for toileting and	F 7	725			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATI COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	risk for skin breakde assistance. The ca call light in reach ar When interviewed of stated R13 was tota cares. Sometimes F breakfast as they di her up before break up, but is agreeable Often R13 would be were able to attend When interviewed of stated when coming they would find R13 often the only staff competent to use th get R13 up, and du in bed at supper tim they just didn't have her up. When interviewed of stated she is incont medical condition, s periods of time to b In addition, she ofte because there is no This was upsetting R13's call light logs reviewed. R13's cal 10 and 20 minutes 30 and 40 minutes between 40 and 50 between 50 and 60	own and required staff re plan indicated to keep the ad answer promptly. on 9/24/20, at 1:31 p.m. NA-C ally dependent on staff for R13 had to stay in bed for idn't have enough staff to get (fast. R13 would prefer to get a when they need her to be. e, "saturated" by the time they to her after breakfast. on 9/24/20, at 3:22 p.m. NA-D g on for the afternoon shift 8 soaked in urine. NA-D was on afternoons who was he mechanical lift needed to e to this, often R13 had to stay he. This would upset R13, but e enough help to always get on 9/28/20, at 11:05 a.m. R13 inent of urine due to her she often has to wait extended e changed in order to be dry. en is unable to get out of bed of enough staff to help her up.	F7	725			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATI COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 49	F 7	25			
	R12 had moderate was on hospice ser care. R12's diagnos disease, asthma/ch disease or chronic l failure.	S dated 8/14/20, included, cognitive impairment. R12 vices and required oxygen ses included coronary artery ironic obstructive pulmonary lung disease and respiratory					
	report (MAR/TAR), staff, "Connect 02.1 bedtime." and "Oxy cannula while at res marked as complet 9/17/20. The MAR/ has bipap on every cpap placement. Pl every hour overnigh completed on 9/4/2 "Bipap-Nurse must sleeping and at night	nd treatment administration dated August 2020, directed I.5 L [liters]/min [minute] at gen at 1.5L/min per nasal st and at night. This was not ed on the night of 9/4/20 and TAR directed "Ensure resident overnight, every night shift for ease ensure Cpap is in place nt." This was not marked as 0 and 9/17/20. and put on use daily when ht." This was not marked as t of 9/4/20 and 9/17/20.					
	family had concerns	p.m. LPN-B stated, R12's and s about staffing. LPN-B R12 "needier," than other					
	R12, (FM)-A stated through video. R12 and oxygen nasal of assist with respirato would notice times not applied, or not a amounts of time, no 3:20 a.m. to 3:50 a.	9 a.m. a family member of she monitored R12's care wore a bipap mask at night annula during the day to ory and breathing issues. FM-A R12's bipap or oxygen was applied properly for significant oting recent example between m.; 5:00 a.m. to 7:10 a.m., :17 a.m. on 9/24/20. FM-A					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	rement of deficiencies (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245090					C 09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASANT MANOR LLC					7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	reported, during the the facility to alert s the interview, R12 r when she was not g needed, like she was R12 was deterioratii physically and was the oxygen. FM-A s she noted no came movement detected 11:34 p.m. and 4:09 required frequent m was on properly. FM she felt like a burde had informed the di concerns and there improvement. R12's call light log, included, R12 active Eleven of those wer minutes. Six were a minutes. Six were a minutes a minutes. Six were a minutes	ge 50 ese instances, she would call taff, without response. During noted she did not feel well getting the oxygen she as in a "daze". FM-A reported ng both cognitively and more confused when not on tated, on 9/18/20 to 9/19/20 ra activity, indicating no d, in R12's room between D p.m. FM-A noted R12 nonitoring to ensure her bipap M-A reported R12 had told her en to staff. FM-A reported she rector of nursing of her was no resolution or dated 9/1/20 to 9/29/20, ated the call light 66 times. re answered in 10 to 20 answered between 20 to 30 answered between 30 to 40 answered between 40 and 50 answered in over 60 minutes on 9/24/20, at 12:23 p.m. were not enough staff to care A explained there were e aide on west side of the care vere not getting the timely care mely toileting, bathing and burnout and turnover. LPN-A cussed concerns with DON nd there had been no eported she helped the with cares when she was able completing treatments and	F 7	[.] 25			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING			C 09/28/2020	
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	medication pass for there was an overa getting the timely as hygiene. When interviewed of reported she was p assistant duties to h appointments and w sufficient nursing st peri-cares for reside busy with their own time baths and sho residents were not evening cares when chart a resident refu- had not been offere bathed, when they been reported to bo with no changes. When interviewed of stated she worked to times when she wo building. Resident extended periods o hour. They just cou- meal times resident there was nothing to when interviewed of stated there was or residents. Nurses of personal cares for sta addition to their reg	ge 51 r residents. LPN-A reported Il concern with resident not ssistance with bathing and on 9/24/20, at 1:31 p.m. NA-C ulled away from her nursing help with electronic medical wound rounds. There was not aff to provide oral care and ents. The nurses were too duties to assist. Most of the wers were missed and assisted with morning and in they preferred. Staff would used a bath, when the resident ed, or chart a resident was were not bathed. This had oth the DON and administrator on 9/24/20, at 3:22 p.m. NA-D the night shift and there were uld be the only nurse aid in the call lights were on for f time- sometimes over an uld not get to them timely. At ts complain of cold food. daily occurrence." This had e administrator but was told hey could do about it. on 9/24/20, at 3:45 p.m. LPN-B he or two aides for 30 were expected to provide 5 residents each shift in ular duties. Sometimes, they ake sure resident treatments	F	725			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING	i		C 09/28/2020	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	staffing agency, the they do not have en their work. LPN-B I management and w When interviewed of HSK-A stated nursin "burned out," becau time to meet reside When interviewed of administrator, assis RN-A were interview facility assessment staffing needs to maneeds. Typically, the assistant per 10 resident were residents who wait times, particula "The staff have made noticed "a lot of state administrator noted dynamics and cultur staffing concerns. The was committed to in and chipping in with she felt there was a but felt the community reported there was too many staff and reported there was census was down. The facility staffing staff, "Our facility prist staff with the skills a provide care ad ser accordance with resident	by are reluctant to return as nough time to complete all of had reported this concern to vas told they had enough staff. on 9/25/20, at 11:12 p.m. ng assistance seem to be, use they do not have enough nt needs. on 9/28/20, at 3:36 p.m. the tant administrator, DON and wed together. There was no to determine the specific eet resident care planned here should be 1 nursing sidents. DON stated there o complained about call light arly at night time. RN-A stated, de it seem so drastic" but	F	725			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI		ATE SURVEY
) PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _	C	OMPLETED
		245090	B WING			С
	PROVIDER OR SUPPLIER	243090			TREET ADDRESS, CITY, STATE, ZIP CODE	9/28/2020
					7 BRAND AVENUE	
LEASA	NT MANOR LLC			F/	ARIBAULT, MN 55021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 725	Continued From pa	ae 53	F 7	725		
-	• • • • • • • • • • • • • • • • • • • •	ect care staff are determined		20		
	by the needs of the	residents based on each				
	resident's plan of ca Food in Form to Me		Г	305		11/2/20
	CFR(s): 483.60(d)(FC	505		11/2/20
	., .,					
	§483.60(d) Food ar Each resident recei	nd drink ives and the facility provides-				
	to meet individual n	l prepared in a form designed leeds. NT is not met as evidenced				
	review, the facility factoriance with res	tion, interview, and document ailed to prepare food in sidents needs for 2 of 3 R10) reviewed who required ets.			F805=D. Based on observation, interview, and document review, the facility failed to prepare food in accordance with residents needs for 2 or 3 residents reviewed and required	
	Findings include:				modified texture diets. Pleasant Manor residents have the right	
	cognitively intact wi	S dated 7/14/20, included th diagnoses of diabetes and required supervision and set eating.			receive food prepared in a form designe to meet their individual needs. Pleasant Manor staff have a responsibility to monitor and ensure that the residents receive food prepared in a form to meet their individual needs.	
	included a diagnosi dysphagia (difficulty throat) and oral pha in the mouth). The risk for aspiration o Recommendations consistency, small	were made for puree bites thorough mastication			The associated policies related to servin appropriate diet texture have been reviewed and remain appropriate. All residents diet textures were reviewed and remain appropriate. All physician orders match culinary meal card system Education was provided to all staff regarding serving appropriate modified	
	bite/sip, slow pacing between liquids/sol	bites before taking another g, single sips, alternate ids. The report indicated uld be required to determine if			diet textures during meal time. Culinary Director/Dietitian or designee w perform audits weekly x 4 weeks, month x 3 months, and quarterly thereafter to	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED		
		245090	B. WING				C 28/2020		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
PLEASA	NT MANOR LLC			27 F/					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 805	Continued From pa	ge 54	F 8	305					
	R10 would be appro	opriate for diet upgrade.			ensure compliance. Audit results w				
	R10's nutritional status CAA dated 4/10/20, identified a risk factor of a mechanically altered diet. No analysis of this risk factor was completed.				reviewed monthly at QAPI meeting further recommendations. Completed 11/2/2020	s for			
	nutritional alteration meals; had diet res [National Dysphagia ground or are minor pieces, they are mo and could have req directed to monitor,	ed 4/1/20, included, risk for related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be ed no larger than 1/4 inch sist, with some cohesion] diet uested puree. Staff were document, and report to the d for signs and symptoms of is.							
		ing assistant Care Guide al soft diet with pureed meat.							
	identified a mechan meat. Speech ther	luation dated 4/16/20, ical soft diet with pureed apy recommended to, "have nless resident request pureed							
		Evaluation dated 7/14/20, full upper and lower dentures.							
	was observed to be 12:47 p.m. it was no hamburger patty on hard to eat because dentures in. She ha as the staff had grill desired one. R10 c	on 9/25/20, at 12:42 p.m. R10 coughing while eating. At oted R10 was eating a regular a bun. R10 stated it was e she did not have her ad requested the regular patty led out the burgers and she continued to cough while sked to see if she was alright,							

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		AND HUMAN SERVICES				FORM	: 11/02/2020 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` ´		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING	i			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 805	nor did anyone brin R10's lunch tray ticl texture and to provi potato salad, no ray lettuce." When interviewed of aide (DA)-A stated mechanical soft die with ground meat. she normally does of When interviewed of (CK)-A stated, a me ground meat, no bri cook is the person of correct diet is serve	ig her dentures. ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating. on 9/25/20, at 1:12 p.m. cook echanical soft diet should have read or hard vegetables. The responsible to ensure the	F 8	305			
	stated R10 does co unaware R10 did no stated if someone is should go get a nur in the dining room. When interviewed of stated she normally today got a regular grilling them. R10 s dentures, but forgot have to remind her them. At 1:39 p.m. asked her if she wa When interviewed of stated resident's die wished for an upgra	bugh at meals, she was ot have dentures in. NA-F s coughing like that, they rese to assess if no nurse was on 9/25/20, at 1:34 p.m. R10 y gets a ground burger, but whole burger as they were stated she normally wore her t them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H					

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		AND HUMAN SERVICES				FORM	: 11/02/2020 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED	
		245090	B. WING	i		C 09/28/2020		
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 805	a risk versus benef she given the risks a regular hamburge When interviewed of Cook-A stated they who had signed a r for a diet upgrade, t they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Gr consistency and pa pureed food if desir When interviewed of registered dietician coughing during a r the DON, food serv therapy. This had r facility should not p diet without risks be and a form signed. When interviewed of DON and RN-A sta the correct diet text swallowing problem if a resident is coug R5's quarterly MDS	its statement signed nor was of choking when provided with er today. on 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the s ordered and not a regular tion Form provided by Cook-A had been completed by d indicated R10 was to have a round Meat NDD2 diet atient could downgrade to red. on 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to vice director and speech not been done for R10. The rovide an upgraded texture eing explained to the resident	F	305				
	DON and RN-A sta the correct diet text swallowing problem if a resident is coug R5's quarterly MDS cognitive impairment	ted it is important to provide ture for residents with ns. A nurse should be notified ghing. 6 dated 9/4/20, indicated no						

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245090	B. WING			C 09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa coughing and choki swallowing medicat period. The MDS fu oversite, set up whe altered textures. R5's Speech Thera indicated diagnoses and oral phase dysp indicated R5 had m the evaluation had f dentures that did no without dentures, R consistency solids a Advanced. R5 was of materials into the penetration (passag and/or asphyxiation R5's Care Assessm dated 1/20/20, indic mechanically altere completed, but was planning. R5's care plan date risk for nutritional al pain front thorax an diet. Staff were dire and report to physic dysphagia when ea R5's Progress note	ing during meals or when tions during the assessment in ther indicated supervision, en eating and mechanically py Evaluation dated 1/25/19, s of cerebral infarction (stroke) phagia. The evaluation further issing teeth, and at the time of full upper and partial lower of fit. The evaluation indicated to could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx,) thent Area Worksheet (CAA) cated R5 required a id diet. There was no analysis is noted to proceed to care and 3/20/20, indicated R5 was at literation related to chronic id diet restriction for NDD3 acted to monitor, document cian for signs or symptoms of ting. dated, 1/25/19, indicated her	F 8	05		NATE	DATE
	R5's Nutritional Eva	o NDD3 by Speech therapy. aluation dated 9/4/20, identified D3, Dysphagia Advanced diet					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT AND PLAN ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED	
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 805	R5's Care guide for and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticko Dysphagia Advance further directed to p hamburger on bun, vegetables, backed lettuce, soft ice creat During an observat R5 sat alone at a tar while she ate her m whole hamburger w covered the burger There were various area including nurs stopped to see why p.m. R5 was observ for someone get a having a seizure. S of the dining room. When interviewed of stated R5 should have beans, potato salad should not have ha have been ground a potato chips or who When interviewed of stated she has occa "spells," and has no	 staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, d care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw l beans, no bacon, shredded am and milk. ion on 9/25/20, at 12:50 p.m. able and was noted to cough real. R5's plate contained a <i>vi</i>th a wedge of lettuce that on a bun and potato chips. staff throughout the dining ing and dietary, but no one R5 was coughing. At 12:52 wed to be shaking and asked nurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A ave received ground meat, d, soft cooked vegetables. R5 d a bun, the burger should and should not have received ble leaf lettuce. on 9/25/20, at 1:10 p.m. R5 asional seizure that are like, 	F 8	805			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l` í		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245090	B. WING			C 09/28/2020	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 805	have ground meat, For the noon meal mechanical texture ground hamburger, was the cook's resp resident is getting the When interviewed of stated staff should coughing and should have received the of who gave her the w When interviewed of Dietary Aide-A repo- aides deliver meal the When interviewed of stated a resident is upgraded texture if been signed. The re- order from the physic and benefit form. R On 9/25/20 at 3:08 should have received not, the Cook is resp correct diet. The facility Refusal and Benefits policy resident would be in benefits of necessar opportunity regardin care. The resident of times and if resident	no bread or hard vegetables. provided on 9/25/20, a should have included, no bun, potato salad and beans. It ponsibility to make sure a he appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ld get a nurse. R5 should correct diet and did not know rrong diet. on 9/25/20, at 1:40 p.m. rted both dietary and nursing	F 8	305	· · · · ·		

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				_ 28/2020
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASANT MANOR LLC					27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 805	Continued From pa	ge 60	F٤	305			
	Dysphagia Mechan Level 1 are allowed foods may be groun no larger than one is should be easy to of Moistened ground of fish. Moist ground with gravy or sauce pureed bread mixes and slurred breads thickness of produce products. Vegetables	hagia Diet indicated NDD2 as ically Altered. All foods on . Meats and other select nd or minced into small pieces forth inch. All food items hew. Meats should be or cooked meat, poultry, or or tender meat may be served a Breads products can be s, moistened bread crumbs that are gelled through entire at and to avoid all other bread es should be soft, well-cooked ables should be less than 1/2 easily mashed with a fork.					

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>DMB NO</u>	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	CON	TE SURVEY MPLETED
		245090	B. WING				C / 28/2020
NAME OF F	PROVIDER OR SUPPLIER			ç	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	FC)00			
F 650	survey was completed complaint investigated not to be in compliated Requirements for L. The following complete substantiated: H5090056C at F68 H5090057C at F67 H5090059C at F67 H5090059C at F67 The following complete substantiated: He following complete form. Your allegation of the form. Your electron be used as verificated Upon receipt of an on-site revisit of your validate that substantiated regulations has beer your verification.	77 and F725 7, F686 and F725 blaints were found to be 15090055C and H5090058C. f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with					11/0/20
F 550 SS=D	0		F 5	50			11/2/20
	self-determination, access to persons a	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
LABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						10/30/2020

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

PRINTED: 11/02/2020

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245090	B. WING			(09/2) 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	with respect and dig resident in a manner promotes maintena her quality of life, re- individuality. The fa- promote the rights of §483.10(a)(2) The fa- access to quality ca- severity of condition must establish and practices regarding provision of service residents regardless §483.10(b) Exercise The resident has th- rights as a resident or resident of the U §483.10(b)(1) The f resident can exercise interference, coerci- from the facility. §483.10(b)(2) The r free of interference, reprisal from the fac- rights and to be sup exercise of his or he subpart. This REQUIREMEN by: Based on observat review, the facility fac-	ility must treat each resident gnity and care for each er and in an environment that nce or enhancement of his or ecognizing each resident's cility must protect and of the resident. Facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the s under the State plan for all s of payment source. e of Rights. e right to exercise his or her of the facility and as a citizen nited States. Facility must ensure that the se his or her rights without on, discrimination, or reprisal resident has the right to be coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this NT is not met as evidenced ion, interview, and document alled to provide care in a ted dignity for 1 of 1 resident	F	550	F550=D. Based on observation, interview, and document review, the facility failed to provide care in a mathat promoted dignity for 1 of 1 resi (R7) reviewed for dignity concerns.	anner	

Facility ID: 00568

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM	11/02/2020 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245090	B. WING			09/28/2020	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Findings include: R7's admission Min 7/28/20, included m with a diagnosis of incontinent and req person to transfer of R7's ADL (activities Rehab Care Assess dated 9/25/20, includ decline in mobility, v of bowel and bladde toileting upon reque R7's care plan date required assistance dependent assist, d personal hygiene se occasionally inconti with toilet use." When Interviewed of was lying in bed. R7 facility is very bad. If there seems to be r facility. Call lights ca hour. I push the call bathroom and no on wet myself. I feel h chair and embarras cleaned up and chair brow was furled and R7 stated this happ When interviewed of nursing assistant (N wait for assistance	imum Date Set (MDS) dated oderate cognitive impairment a stroke. R7 was occasionally uired assistance by one staff on and off of the toilet. of daily living)/Functional sment Area Worksheet (CAA) ided, R7 has had a recent was occasionally incontinent er, and needed assistance for	F 5	50	The residents of Pleasant Manor have right to receive care in a dignified man It is the responsibility of all staff of the facility to ensure the residents' plan of care promotes their dignity and reside rights. The associated policies related to providing care in a dignified manner we reviewed and remain appropriate. R7's plan of care for toileting was reviewed and remains appropriate for currently level of function. All resident toileting plans have been reviewed, discussed as an IDT and toileting plan appear to be appropriate at this time. additionally will implement a Resident Advocate Program that will assist in promoting timely response to resident concerns. Education of executing a toileting plan and IDT will be educated on Resident Advocate Program. Administrator/DON or designee will perform audits weekly x 4 weeks, mo x 3 months, and quarterly thereafter to ensure compliance. Audit results will reviewed monthly at QAPI meetings f further recommendations. Date of completion: 11/2/2020	enner. e of ent were r nt's . IDT t nt n of staff t onthly to be	

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			```		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING			09/28/2020	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Most residents wait time to receive an a has assisted R7 aft secondary to waitin time for the call ligh that there have bee beginning of the shi soiled and need as night shift is custom one licensed praction nurse (RN) for the 4 facility. When interviewed of LPN-D state there i individual needs of among staff and res R7 being incontinent to her timely is a dig R7's call light respon 9/22/20, at 3:51 a.n showed the call ligh the seven day period initiated, 11 (or 21.5 15 minutes to recein 14%) of these alerts to receive a respon During a phone call p.m. the administra staffing or facility as determining staffing administrator stated include one staff me "More comradery a was needed among	for an extended period of answer to their call light. NA-D er R7 was incontinent g for a prolonged period of it to be answered. NA-D stated en, "too many times," at the iff when several residents are sistance. NA-D stated the narily staffed with two NA's and cal nurse (LPN) or registered 42 current residents in the on 9/25/20, at 2:55 p.m. s insufficient staff to meet the each resident. The morale sidents is low because of this. It due to not being able to get gnity issue. onse time logs dated from n. to 9/28/20, 9:25 a.m. it was engaged 51 times over bd. Of the 51 call light alerts 5%) of these alerts took over ve a response. Seven (or s took longer than 20 minutes se. Interview on 9/28/20, at 3:30 tor stated they do not have a ssessment in place to assist in g needs at this time. The d current staffing rations ember for every ten residents. nd better communication," g the staff. These measures a. The administrator stated that	F 5	550			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625 SS=D		Policy Before/Upon Trnsfr 1)(2)	F6	625			11/2/20
	§483.15(d) Notice c	f bed-hold policy and return-					
	nursing facility trans the resident goes o nursing facility mus the resident or resident specifies- (i) The duration of the any, during which the return and resume facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing fac bed-hold periods, w paragraph (e)(1) of resident to return; a	e before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the t provide written information to dent representative that the state bed-hold policy, if he resident is permitted to residence in the nursing payment policy in the state 0 of this chapter, if any; ility's policies regarding thich must be consistent with this section, permitting a nd specified in paragraph (e)(1)					
	the time of transfer hospitalization or th facility must provide resident representa specifies the duration described in paragr This REQUIREMEN by: Based on document facility failed to issue	erapeutic leave, a nursing to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section. NT is not met as evidenced nt review and interview, the e a written bed-hold notice hospital for 1 of 3 residents			F625=D. Based on document revi interview, the facility failed to issue written bed-hold notice upon transfe the hospital for 1 of 3 residents (R1 reviewed for hospitalizations. Prior to transfer, it is the responsibi the Pleasant Manor staff to offer a v	a er to) lity of	

Event ID: 2XHN11

Facility ID: 00568

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625 F 677 SS=D	5/20/20, indicated F 5/14/20 with a disch anticipated MDS da R1's progress note included, R1 was tra full report was given teams. However a b in R1's medical reco When interviewed of guardian reported s bed hold notification possibility to hold th When interviewed of interim director of n bed hold notice was Facility policy titled, Emergency revised bullet number 4: "Th responsible for: b. or her representativ readmission appeal ect." ADL Care Provided CFR(s): 483.24(a)(2) §483.24(a)(2) A res out activities of daily services to maintain personal and oral h This REQUIREMEN	imum Data Set (MDS) dated R1 was admitted to facility on harge assessment-return htted, 9/16/20, at 6:24 p.m. ansferred to the hospital and a in to the police and transport bed hold notice was not found ord. on 9/24/20, at 3:07 p.m. R1's she had not been provided a in and was unaware of the he bed for R1. on 9/28/20, at 2:09 p.m. the ursing (DON) verified a written is not completed for R1. Transfer or Discharge, on 08/2018, indicated under he business office is Informing the resident, or his ve (sponsor) of our facility's I rights, bed-holding policies, for Dependent Residents 2) ident who is unable to carry y living receives the necessary in good nutrition, grooming, and		\$25 \$77	bed-hold to the resident being trans The bed-hold policy has been review and remains appropriate. All nurses and IDT members will be educated on the bed-hold policy and steps to carry out offering a bed-hold during a transfer to the hospital. Administrator or designee will perfor audits weekly x 4 weeks, monthly x months, and quarterly thereafter to a compliance. Audit results will be rev monthly at QAPI meetings for further recommendations. Completed 11/2/2020	wed d the d rm 3 ensure riewed	11/2/20
		ion, interview, and document ailed to provide incontinence			F677=D. Based on observation, interview, and document review, the	•	

Facility ID: 00568

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							0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X		SURVEY
						C)
		245090	B. WING			09/2	8/2020
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 677	Continued From pa	age 6	F 6	77			
		led to reassess continence	_		facility failed to provide incontinence	care	
		ficant change for 1 of 3			timely, and failed to reassess contine	ence	
	residents (R3) revie	ewed for incontinence.			status after a significant change for 1 residents (R4) reviewed for incontine		
	Findings include:				Pleasant Manor staff have the		
	-				responsibility to provide care to reside		
		nimum Data Set (MDS) dated			who are unable to carry out activities	of	
		moderate cognitive impairment uding diabetes, dementia and			daily living to promote their health, including assessment during their sta	av.	
		ed extensive assistance with			and providing care daily.	ау	
	toileting and limited	l assistance with personal			The associated policies related to toil		
	hygiene. R4 was not on a toileting program and				plans have been reviewed and remain	in	
	times during the as	ncontinent of urine (less than 7			appropriate. R4's toileting plan was reviewed and updated. All resident's		
		sessment periody.			toileting plans have been reviewed,	,	
		Care Area Assessment (CAA)			discussed as an IDT and toileting pla		
		ted, "Resident triggers for			appear to be appropriate at this time.	•	
	assistance with toil	e r/t [related to] need for et use and bladder			Staff will be educated on executing toileting plans per plan of care.		
		e is in PT [physical therapy]			DON or designee will perform audits		
	and OT [occupation	nal therapy] at this time with			weekly x 4 weeks, monthly x 3 month		
		g to the community. Resident			and quarterly thereafter to ensure		
		products to aid in keeping skin le to with current toileting plan			compliance. Audit results will be revie monthly at QAPI meetings for further		
		cares q [every] AM [morning],			recommendations.		
		n each incontinent episode."			Completed 11/2/2020		
	R4's significant cha	ange MDS dated 8/27/20,					
		gnitive impairment, was totally					
	dependent upon st	aff for toileting and personal					
	hygiene and was a	lways incontinent of urine.					
	R4's incontinence	CAA dated 8/28/20 included,					
	"Resident triggers f	for urinary incontinence r/t					
		der incontinence. Resident has					
		obility and cognitive function. nrolled in hospice for end of					
		t uses incontinence products to					
		dry. Plan to continue to with	1				

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	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	СОМ	E SURVEY PLETED C
	245090	B. WING	i			28/2020
NAME OF PROVIDER OR SUPPLIE	R		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASANT MANOR LLC				7 BRAND AVENUE FARIBAULT, MN 55021		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
[every] AM [morrincontinent episoR4's only Bowel a medical record w R4 was continentR4's care plan da "Alteration with e to, "Assist of 1 w not been updated 8/27/20, MDS no incontinence to ta in assistance need hygiene.R4's nursing ass "Assist of 2 w/ Ha ambulate." No ir nursing assistant toileting needs.During continuou starting at 10:34 if she would like declined. No enc provided. No add incontinence card licensed practica her room to check insulin. LPN-D th room. Incontinen 1:58 p.m. NA-F a and changed R4	blan and complete peri cares q ing], HS [night], and with each		677			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		245090	B. WING _			09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 677	since getting her up "There are only two best, it is terrible." I we can't get to her, NA-B acknowledge without being assist When interviewed of director of nursing (should be assisted hours. The DON st needs very well. Re was present review and Bladder assess 6/24/20, noting it in bladder. RN-A revie identified R4 had no Bladder assessmer significant decline in June of 2020. RN-/ an updated assess change MDS comp explained they were R4 was on their wor should have been of changed at least ev The facility policy To 11/2019) identified, incontinence produc change as needed." Planning" (revision care plan is to be m condition and care of changes." Treatment/Svcs to F	ist R4 to lie down or toilet of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. on 9/28/20, at 3:05 p.m. the DON) stated, she thought R4 with incontinent cares every 2 rated she did not know R4's egistered nurse (RN)-A who ved R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and of had an updated Bowel and nt, even though she had a in condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4 shecked for incontinence and rery 2 hours. bileting Assistance (policy date "If a client wears an ct, check if soiled or wet and " The facility policy Care date 6/2019) identified "The nodified and updated as the needs of the resident Prevent/Heal Pressure Ulcer	F 67				11/2/20
F 686 SS=D	CFR(s): 483.25(b)(r 00				11/2/20

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
		TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	(EACH CORRECTIVE ACTION ADDITION CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa	ge 9	F 6	86			
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review, the facility fa timely for 1 of 3 res were at risk of deve Findings include: R4's significant cha dated 8/27/20, inclu impairment with a d required extensive a total staff assistanc for pressure ulcer d a current pressure ulcer (CAA) dated 8/28/2 for pressure r/t [rela with bed mobility ar incontinence. Resid down r/t cognitive ir	sure ulcers. rehensive assessment of a must ensure that- es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition hey were unavoidable; and oressure ulcers receives and ards of practice, to event infection and prevent veloping. NT is not met as evidenced ion, interview, and document ailed to provide repositioning idents (R4) reviewed who eloping pressure ulcers. nge Minimum Data Set (MDS) uded severe cognitive liagnosis of dementia. R4 assist for bed mobility and e for transfer. R4 was at risk evelopment, but did not have			F686=D. Based on observation, interview, and document review, the facility failed to provide repositioning timely for 1 of 3 residents (R4) revie who were at risk of developing press ulcers. Pleasant Manor staff have the responsibility to provide care to resid who are unable to carry out activitie daily living to promote their health, including assessment during their st and providing care daily. The policy named Repositioning wa reviewed and remains appropriate. repositioning plan of care was revie and remains appropriate. R4's skin been reviewed and remains free of alterations. All resident's reposition plans of care have been reviewed, discussed at IDT, and repositioning of care remain appropriate. All nursing staff will be educated on	dents sof tay R4's wed has skin ing plans	

Facility ID: 00568

		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	and daily use of AS [blood thinner]. She bladder. Resident r over skin tear on LI otherwise intact. Pr place with toileting a hours, pressure rec wheelchair and mai cares q [every] AM weekly skin inspect R4's care plan date alteration in skin int "Monitor skin integr inspection by nurse order. Pressure red Pressure redistribut chair." Care plan in R4's care plan furth mobility related to e "Dependent with be staff]. Maxi lift (Hoy transfers. Turn and hours]." Additionally "Alteration in comfo 9/8/20: "Position q2 [as needed] with pil R4's nursing assists "Assist of 2 w/ [with not ambulate." The on how often to ass repositioning. A Hospice Facility N 9/3/20 included, "De to bottom."	A [aspirin] and Coumadin e is incontinent of bowel and noted to have scabbed area LE [lower left extremity]. Skin eventative skin measures in and repositioning q [every] 2 distribution cushion to ttress to bed, routine skin [morning] and HS [night], and tions." ed 6/26/20 included, "Potential tegrity." Staff were directed to, ity daily. Weekly skin e. Treatment to open areas per distribution mattress to bed. tion cushion to wheelchair, terventions updated 9/1/20. her indicated, "Alteration in end of life" with interventions: ed mobility: A1-2 [assist of 1-2 ver) [mechanical lift] with reposition Q2H [every 2 y R4's care plan specified, ort," with an intervention dated 2hrs [every 2 hours] and PRN	Fé	586	repositioning policy. DON or designee will perform audit weekly x 4 weeks, monthly x 3 mor and quarterly thereafter to ensure compliance. Audit results will be re monthly at QAPI meetings for furth recommendations. Completed 11/2/2020	nths, viewed	

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI COM	E SURVEY PLETED
		245090	B. WING	·			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	starting at 10:25 a.r herself in the wheel effectively adjust he members asked R4 R4 verbally decliner offered to recline R declined. No encou provided. No additio occurred. At 11:46 a (LPN)-D brought R4 sugar and administ repositioned. LPN-I room. At 1:55 p.m. NA-B assisted R4 in bed using 2 pillows stated, "Oh God, th pain was in her bac When interviewed of and NA-B stated the morning cares at 7: not had time to ass since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge the same position in repositioned. R4 sh hours. When interviewed of director of nursing (repositioned every 3 The facility policy R 5/2013) identified, " resident who is imm	m. R4 was attempting to adjust lchair, but was not able to erself. At 10:34 a.m. 2 staff 4 if she would like to lay down. d. The 2 staff members 4's wheelchair. R4 verbally tragement or re-approach was onal attempts to reposition a.m. licensed practical nurse 4 to her room to check blood er insulin. R4 was not D brought R4 to the dining nursing assistant (NA)-F and nto bed and positioned her in . As R4 was laid in bed she at hurts." R4 specified that the k. on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with '30 a.m. NA-F stated they had ist R4 to lie down or reposition of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours in n her chair without being hould be repositioned every 2	F	586			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			ATE SURVEY
		IDENTIFICATION NOMBER.	A. BUILD	NG.		C
		245090	B. WING		0	9/28/2020
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
PLEASA	NT MANOR LLC			_	7 BRAND AVENUE ARIBAULT, MN 55021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 686	every 1 hour (q1 ho Residents who are an every 2 hour (q2 schedule." Facility p Wound Manageme	in a chair should be on an bur) repositioning schedule. in bed should be on at least hour) repositioning policy Skin Assessment and nt (revision date 7/2018) skin inspection will be	F	586		
F 689 SS=G	Free of Accident Ha CFR(s): 483.25(d)(§483.25(d) Acciden The facility must en §483.25(d)(1) The r	azards/Supervision/Devices 1)(2) ıts.	F€	89		10/1/20
	supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility fa assess 3 of 5 resid had fallen, and imp prevent further falls for R1 when she su and fractured her sl failed to ensure 2 o reviewed for chokin ordered modified te Findings include: R1's quarterly Minin 8/20/20, included, s with diagnoses inclu	resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview and document ailed to comprehensively lents (R1, R4, and R3) who lement interventions to . This resulted in actual harm istained 19 falls, broke a finger kull. In addition, the facility f 5 residents (R10 and R5) ig risk were served the exture diet.			F689=G. Based on observation, interview, and document review, the facility failed to comprehensively assess of 5 residents (R1, R4, and R3) who had fallen, and implement interventions to prevent further falls. This resulted in actual harm for R1 when she sustained falls, broke a finger and fractured her skull. In addition, the facility failed to ensure 2 of 5 residents (R10 and R5) reviewed for choking risk were served the ordered modified texture diet. Pleasant Manor ensures that the residents' environments remain safe and as free of accident hazards as possible. The facility identifies each resident at ris for accidents and develops a plan of car	19 e I

Facility ID: 00568

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	0938-039 SURVEY PLETED	
		245090	B. WING _	i		(09/2) 28/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 689	(ADL's) and did not falls with injury sinc had a discharge MI R1's falls Care Area included, "Resident having impaired ba medication use. Re following hospitaliza infection] and incre involved in a MVA [November and suff including but not lim rib fractures, and w increased risk for fa agitation, and daily anticonvulsant, ant benzodiazepine me of bowel and bladd history of falls prior any falls since adm to a room closer to Plan to continue to light in reach, and f recommendations.' would be addresse R1's admission Fal 5/19/20, included a falls as identified in there was no analy identification of inter reduce the chance R1's care plan date AEB [as evidenced admission related t	st activities of daily living ambulate. R4 had 2 or more be the prior assessment. R1 DS dated 9/16/20. A Assessment dated 5/22/20, a Assessment dated 5/22/20, a triggers for falls r/t [related to] lance and daily psychotropic esident has decreased mobility ation for a UTI [urinary tract ased behaviors. Resident was motor vehicle accident] last fered multiple major injuries nited to: skull fractures, TBI, rist fractures." "Resident is at alls r/t cognitive impairment, use of psychotropic, ihypertensive, and edications. She is incontinent er. She does not have a to admission and has not had ission. Resident was moved the nurses station for safety. monitor for safety, keep call follow therapy ' The CAA indicated falls d in the care plan. I Review Evaluation dated check list of risk factors for the 5/22/20 CAA. However, sis of fall risk factors or erventions that may mitigate or	F 68	39	addressing safety issues and impler procedures to prevent accidents and incidents. The policy related to assessment of have been reviewed and remain appropriate. The policy related to modified textured diets has been rev and remain appropriate. R4 and R3's incidents have been reviewed, assessed, and plan of car updated. R1 has been discharged f the facility. All resident's incidents h been reviewed, assessed, and plan care updated appropriately. All resid diet textures plans of care have bee reviewed and remain appropriate. Nurses were educated on post fall evaluation process and IDT was edu on the process of incident review an analysis and expectations regarding timely completion. Culinary staff we educated on proper service of modifi textured diets Administrator/DON or designee will perform audits weekly x 4 weeks, m x 3 months, and quarterly thereafter ensure compliance. Audit results wil reviewed monthly at QAPI meetings further recommendations. Completed 10/1/2020	d falls viewed re from nave of dent's n ucated nd l re fied		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	"Resident will be sa should incident occ use one assist for the Place bed on low per- both sides of bed. unless providing ca chair for comfort. T in wheel chair. Pro- taking outside and will R1's Action Summa identified R1 had fa 7/31/20, 8/1/20, 8/5 8/12/20, 8/16/20, 8/ 8/21/20, 8/29/20, 9/ addition, R1's progr 8/30/20 identified sl not included on the no progress notes as the mat next to the bed 8/5/20, 8/6/20, 8/16 times, 8/29/20, 8/30 identified from a wh 9/15/20. 1 fall from was no documental circumstances of th 7/14/20. R1's Incident Revie included, R1 was for Incident Analysis in resident's room and	ge 14 goal for R1 was listed as, ife and free from serious injury ur." Staff were directed to, ransfers with a standing lift. osition. Have fall mats on Leave door open at all times res. Use a tilt-in-space wheel to be visually supervised when vide one on one care, such as wheeling her down the hall. ary dated 7/1/20 to 9/28/20, illen 17 times on 7/14/20, /20, 8/6/20, 8/11/20, 8/12/20, 16/20, 8/16/20, 8/19/20, '3/20, 9/14/20 and 9/15/20. In ress notes dated 7/29/20 and he had fallen, but these were Action Summary. There were or incident reports for the falls tion Summary which were /20 (2 falls), 8/19/20, or the falls were identified in the being a fall from bed onto the . These were on 7/31/20, /20 - three times, 8/21/20-3 D/20, and 9/3/20. 2 falls were heel chair on 8/29/20 and recliner on 7/29/20. There tion to determine the he falls that occurred on 11/20, 8/12/20, 8/19/20 or	F 689			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	which contributes to diagnosis of unspec consciousness; Det disturbance." The f listed: proper footw (physical therapy/od lowest position and to be visually super Provide tilt-in-space recline resident whe comfort. Staff prov such as taking her down the hall. "Res times heard yelling, attention to staff an reassurance. Resid lack of safety award dementia. Residen and restlessness at resident's self trans to tend to her." The to the care plan. R1's progress note [certified nursing as [10:00 a.m.] that res chair. Upon enterin sitting on the footre recliner was tilting f resident back to set R1's progress note 8:40 PM writer heat room and found res to her bed." Abrasi There was no asset Interventions addeo resident's bedroom	b resident's fall risks due to cified TBI w/o loss of mentia with behavioral follow-up/intervention section /ear, evaluation by PT/OT ccupational therapy), bed in soft touch call light. Resident vised when in wheelchair. wheelchair with the ability to en in chair to provide ore iding 1:1 (one on one) care outside and wheeling her sident with behaviors and often Resident requires 1:1 d to redirect and provide dent is at high fall risk due to eness due to TBI and t also experiences agitation nd could be the reason of ferring to get staff's attention ese interventions were added dated 7/29/20, included, "CNA sistant] told writer at 1000 sident had slid forward in her ng room writer found resident st of her recliner and the orward. Three staff assisted at [sic] of the chair." dated 7/31/20, included, "At rd resident calling out from her sident on the floor laying next ons were noted to both knees.	F	589	>		

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	SURVEY PLETED
245090 B. WING 09/28	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 55021	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE C TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE C	(X5) COMPLETION DATE
F 689 Continued From page 16 dark." Keeping the bathroom light on when the room is dark was not added to the care plan. F 689 R1's Incident Review and Analysis report dated 8/5/20, identified R1 was found on the floor on 7/31/20. The report identified R1 wanted to, "get out of room." No further assessment of this fall was documented. However, a new interventions of notifying the nurse practitioner of, "frequent anxiety, agitation, restlessness and request a change in medications to decrease anxiety, restlessness, and agitation," was requested. R1's Incident Review and Analysis report dated 8/5/20, identified R1 had been found on the floor on 8/1/20. The form identified, "Resident wanting to get out of room." This listed the same intervention as the 8/5/20 report for the fall on 7/31/20. There was no assessment completed regarding this fall. R1's progress note dated 8/6/20, included, "Resident found on floor by bed on knees. yelling out. Asked her what she was doing and she said going to the floor." There was no assessment of this. R1's progress note dated 8/16/20, at 3.46 p.m. included, "Writer notified by TMA [trained medication aide] at 1500 (3.00 p.m.] that resident was on the floor." R1 was sitting on floor mat by bed. The note indicated the physician was then notified due to increased anxiety and additional antianxiety medication was ordered. R1 indicated she hurt all over. R1's progress note dated 8/16/20, at 10:28 p.m. included, "Aid called writer into room. Resident	

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	facility." R1's progress note included, "Aid called sitting on floor with was wanting to leav R1's progress note included, "Resident bed. Resident had slid out of her bed. leave facility and ca me out of here." R1's progress note "Writer observed re mat next to bed this at lowest position happened and reside of here." R1's progress note 2:15 PM writer hear Writer found reside her W/C [wheel cha Writer found 1" [inc forehead. Resident footwear, foot peda incontinence noted. to writer what happen	confused and wanted to leave dated 8/16/20, at 10:35 p.m. d nurse in to find resident arms on the bed. Resident	F	589			
	also. R1's progress note "Writer heard repea room and found res	und an abrasion on her knee dated 8/30/20, included, ated yelling out from resident's sident on the floor next to her west position, call light within					

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		AND HUMAN SERVICES			FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	E SURVEY PLETED
		245090	B. WING			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC			7 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689		blace both sides of bed, and	F 689			
	resident not inconti					
	on right index finge There was no incid	dated 8/30/20, noted a bruise r and a scrape on her head. ent report or assessment to ese injuries occurred.				
		dated 8/31/20, included, the updated on bruise to right				
	R1's progress note sore right finger."	dated 9/2/20, included, "Ice to				
	monitor right index	ord identified staff were to finger related to a fall. identify which fall caused this				
	"Writer heard reside when writer arrived floor next to her bee	dated 9/3/20, included, ent yelling from her room and resident was sitting on the d yelling, "Help me get back rest position with fall mats in in reach."				
	there was no comp determine the rease any pattern in time	d fallen from bed 13 times, rehensive assessment to on R1 was falling from bed, of day or situation, or to current interventions were not further falls.				
		dated 9/10/20, included, finger related to a fall." "Nail jer appears black."				
	R1's progress note	dated 9//13/20, identified to,				

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING _				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				' BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	"Patients finger com nail bed no redness remains intact at th R1's Incident Revie 9/15/20, identified F wheelchair on 9/15/ cause of R1's fall fr The form identified emergency room for wound. R1's hospital Admis dated 9/15/20, inclu floor in bedroom an herself on floor at n agitated/verbally up upstairs." The rest an acute nondisplay posterial parietal bo hospital discharge s sustained a closed her right hand 2nd t before returning to fracture was in a st had happened in th an injury to R1's rig progress notes on 8 not assessed by a p hospitalized on 9/18 When interviewed of stated R1 had faller wheel chair, she wa and required one of fall. NA-B stated th on ones with R1. N	a finger related to a fall." titinues to be black around the s or warmth noted to site. Nail is time." w and Analysis report dated R1 had fallen from her /20. No assessment of the om the chair was completed. R1 was sent to the or evaluation due to a head assion History and Physical ided, "Patient was found on id then seemed to throw iursing station. She has been uset at times. Wanting to go ults from a CT of head noted ced fracture of the left one (skull fracture). R1's summary identified R1 had skull fracture and a fracture of finger which would be splinted the nursing home. The finger age of healing, identifying it e past. The facility identified ht index finger in the the 8/30/20. However, this was ohysician or x-rayed until	F 68	39			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT OF DI AND PLAN OF COF	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF PROVI	IDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASANT M	IANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
and sit v as c Why stat scree inte the R1 o rem area but Why gua susi und Why lices con thre was sup any dete was assi she Why	with her one on of other residents r ten interviewed of ted R1 had faller eam and throw h erventions she kr low position and did this she wou hembered R1 ha a on her forehea did not know wh ten interviewed of adian stated the staining a fracture liagnosed for so hen interviewed of nsed practical m estantly throwing eatening to throw s not enough sta pervision with R1 v assessment of ermine why she s R1's behaviors essment of R1's e was, "throwing eaten interviewed of set of nursing (ood system for v trying to improve	up all the time, other than to one, winch was not possible required care too. on 9/24/20, at 1:31 p.m. NA-C in frequently, she would herself from bed. The only new of was to have the bed in d mats on the floor so when uldn't be injured. NA-C id a large swollen egg sized ad and had broken her finger, men this occurred. on 9/24/20, at 3:07 p.m. R1's y were concerned about R1 ed finger that went	F 6	689	DEFICIENCY)		

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		AND HUMAN SERVICES				FORM	: 11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	of these for R1's fall sustained on 7/14/2 9/15/20. The DON assessment had no other falls R1 sustai issues and really re which they were un was unable to provide termine if there w what interventions r anxiety/behaviors the frequently. No assessment	age 21 a DON was only able to find 4 lls, which were for the falls 20, 7/31/20, 8/1/20, and did not know why this ot been filled out for any of the ined. R1 had behavioral equired one on one attention, able to provided. The DON ide any assessment to was a pattern to R1's falls, and may assist R1 with her hat led to her falling so essment had been completed to determine interventions that	F 6	89			
	included severe cog diagnosis of demen disturbance. R4 rec mobility and dressin for transfer, toileting was totally incontine cares 1-3 times dur R3 had 1 fall withou assessment. R4's fall CAA includ r/t having impaired psychotropic medic declined in both mo She has recently er	quired extensive assist for bed ng and total staff assistance g, and personal hygiene. R4 ent of bladder and rejected ring the assessment period.					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	of hypoglycemic, ar narcotic, and psych incontinent of bower recent fall from bed for safety and keep R4's care plan date related to [blank]. S lowest position. Cal Follow PT and OT if function." The most "Ambulate to dining walker] support with 120 ft [feet] x1 [with was added 7/22/20 been made. R4's nursing assista "Assist of 2 w/ [with not ambulate; fall m R4's progress note included, "At 7:35 p lying on floor next to agitated/anxious ar stand/yell at staff. F when trying to positi sling so resident as Ax2 [assist of 2 staf fall mat was in plac lowest position; roo lit." "Resident recein Seroquel [antipsych agitation/anxiety an following hour. Hos of nursing], and em notified. Writer and about in-facility fam	ntihypertensive, diuretic, notropic medications. She is al and bladder. She has had a d. Plan to continue to monitor o call light within reach." ed 6/26/20 indicated, "Fall risk Staff were directed, "Bed in Il light within reach; fall mat. instruction for mobility t recent intervention, g room with FWW [front wheel h CGA [contact guard assist] n 1 staff] with FWW support" . No additional updates had ant Care Sheet included, n] Hoyer [mechanical lift]; Does nat; call light within reach." dated 8/26/20, at 10:51 p.m. om nurse aide found resident o bed. Resident appeared nd continued to try and Resident swinging arms at staff tion Hoyer [mechanical lift] ssisted back up into bed with ff]. Call light was within reach; ee next to bed; bed was in om was clear of clutter and well ved PRN [as needed]		589			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				28/2020
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	contact thought it w Emergency contact visit tomorrow." When interviewed of registered nurse (R incident report or po fall. R4's care plan R4, as she is no lor When interviewed of family member (FN allowed to visit rela concerned about R would not be able to a visit. No one had possibly visiting to of When interviewed of LPN-D stated R4 has rolling from bed. The to the bed and make reach. LPN-D stated use the call light an intervention. When interviewed of stated, R4 was to h visits after this fall the The DON stated, the meet after each fall plan, and communi increased family vision communicated to the plans. R3's admission MD	 yould be worth a try; tis going to try and stop for a on 9/28/20, at 10:00 a.m. cN)-A stated there was no ost fall follow-up report on R4's was incorrect about walking nger able to ambulate. on 9/28/20, at 11:35 a.m. 1)-B stated they had not been ted to COVID and was 4's falls. FM-B stated R4 o see them out her window for 1 spoken to them about decrease anxiety. on 9/28/20, at 12:35 p.m. ad fallen a couple times, hey put a mat on the floor next te sure R4 has her call light in ed R4 would not know how to id was unsure why that was an on 9/28/20, at 3:05 p.m. RN-A have increased family window o aide in preventing more falls. in terdisciplinary team should i, update care sheets and care cate the change, but the 	Fθ	\$89			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	including a stroke a extensive staff assi daily living (ADL's), of falls prior to adm admission with no i delusions or halluci R3's falls CAA date triggers for falls r/t h history of falls, and Resident has had a following hospitaliza weakness. He had increased right side OT at this time with community. Reside r/t daily antihyperter and hypoglycemic r of bowel and bladde vision, and hearing of falls prior to adm since admission wh something on the fl monitor for safety, k follow therapy recor would be completed R3's Fall Review Ev included a checklist before admission, f use that can increas deficits, incontinent concerns with balar findings or indicatio factors would be ad R3's care plan date related to lack of sa	and dementia. R3 required stance with most activities of was unsteady, had a history ission and had fallen since njury. R3 did not have nations. d 8/19/20, included, "Resident naving impaired balance, daily antidepressant use. recent decline in mobility ation for increased overall a CVA [stroke] and has e weakness. He is in PT and the goal of returning to the ent is at increased risk of falls nsive, psychotropic, diuretic, medications. He is incontinent er. He has impaired cognitive, . Resident does have a history ission and has had one fall here he was reaching for oor. Plan to continue to keep call light in reach, and mmendations. Care planning d. valuation dated 8/15/20, t of risk factors including fall all after admission, medication se falls, cognition and sensory ce, confined to chair, and nce. There was no analysis of n on how any of these risk	F	589			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Answer call light pro for transfers, follow in reach, proper foo items were in reach R3's progress note included, "Writer wa walked in and saw f floor. Resident was eating supper. Aid, resident up using he Resident states tha dropped and he we his wheelchair. Res on the chair that wa R3's progress note included, "Resident was at the medicine "Pt [patient] was att RN heard some sou his wheel chair and saw the resident fal R3's progress note "Writer was called to floor. Resident wa and had his hands I Resident was sitting sitting up. Resident his wheel chair to g slipped off the bed a bed. Resident's vita limits. Resident wa for all transfers."	 Staff were directed to, omptly, use a mechanical lift therapy instructions, call light set to the therapy and therapy and the therapy and therapy a	F 6	689			
		ansferred and was found					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	"Resident was layin	-	F 68	9		
	waiving it in the air. right next to him wit Resident states he his room and using out of his way. Res wheelchair while do there were no cats assessment of R3's room, even though	Residents wheelchair was the breaks unlocked. was chasing the cats out of the handle gripper to get them sident then fell out of oing this." "Resident was told in this facility." There was no so belief there were cats in his R3 had not had hallucinations time of the comprehensive				
	LPN-C stated other care plan, no new ii any of these falls. I any post fall assess The facility had not determine root caus prevent the falls fro increased confusion not assessed other which the family de interdisciplinary tea next day and place that assessment, b R3.	on 9/28/20, at 10:31 a.m. than what was already in the nterventions were added after _PN-C was unable to provide sment for any of these falls. assessed each fall to se, nor place interventions to m happening again. R3 had n after admission, which was than to offer psych services, clined. Normally, the m would assess each fall the new interventions based upon ut this had not been done for				
	DON and RN-A star to provide the docu resident's who had facilities, "Risk man	on 9/28/20, at 11:44 a.m. the ted the facility was not willing mentation related to any of the fallen as it is part of the nagement." They were unable imentation that R1, R4, or				

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		AND HUMAN SERVICES				FORM	: 11/02/2020 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING	;			C 28/2020
NAME OF	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	R3's falls had ever assessed to determ prevent further falls A facility policy titled Management, revis procedure for staff a fall, "staff will mor resident's response intervention put in p 72 hours post fall. 2 staff will re-evaluate appropriate to contri interventions. As ne provider will assist not previously ident documented that fa will implement appr prevent serious injube updated to reflee R10's quarterly MD cognitively intact wi lung disease. R10 up assistance with R10's Speech Ther included a diagnosi dysphagia (difficulty throat) and oral pha in the mouth). The risk for aspiration o Recommendations consistency, small (chewing), swallow bite/sip, slow pacing between liquids/sol	been comprehensively nine interventions that may s from occurring. d, Fall Prevention and sed 2/2020, indicated follow-up after a resident had sustained nitor and document the e to and the effectiveness of blace to prevent further falls for 2. If resident continues to fall, e the situation and whether it's inue or change the current eeded, the resident's medical reconsider possible causes tified. 5. If it is determined and alls may be unavoidable, staff ropriate interventions to ury from falls. 6. Care plans will ct fall interventions." PS dated 7/14/20, included ith diagnoses of diabetes and required supervision and set eating.		689	,		

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		AND HUMAN SERVICES			FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245090	B. WING			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 689	Continued From pa R10 would be appro R10's nutritional sta identified a risk fact diet. No analysis of completed. R10's care plan dat nutritional alteration meals; had diet res [National Dysphagia ground or are minor pieces, they are mo and could have req directed to monitor, physician as neede swallowing problem R10's undated nurs included mechanica R10's Nutrition Eva identified a mechan meat. Speech ther all meats ground, u for preference." R10's Oral/Dental E indicated R10 had f	age 28 opriate for diet upgrade. atus CAA dated 4/10/20, tor of a mechanically altered f this risk factor was ted 4/1/20, included, risk for n related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be ed no larger than 1/4 inch bist, with some cohesion] diet juested puree. Staff were , document, and report to the ed for signs and symptoms of	F 68	DEFICIENCY)	RIATE	DATE
	dentures in. She ha as the staff had gril desired one. R10 c	e she did not have her ad requested the regular patty led out the burgers and she continued to cough while cked to see if she was alright,				

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STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 689	Continued From pa nor did anyone brin	-	F€	689			
	R10's lunch tray ticl texture and to provi	ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded					
	aide (DA)-A stated mechanical soft die	on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating.					
	(CK)-A stated, a me ground meat, no br	on 9/25/20, at 1:12 p.m. cook echanical soft diet should have ead or hard vegetables. The responsible to ensure the ed.					
	stated R10 does co unaware R10 did no stated if someone is	on 9/25/20, at 1:21 p.m. NA-F ough at meals, she was ot have dentures in. NA-F s coughing like that, they se to assess if no nurse was					
	stated she normally today got a regular grilling them. R10 s dentures, but forgot have to remind her	on 9/25/20, at 1:34 p.m. R10 / gets a ground burger, but whole burger as they were stated she normally wore her t them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H as ok.					
	stated resident's die wished for an upgra	on 9/25/20, at 3:06 p.m. RN-B ets could be upgraded if they ade, but would have to sign a s statement. R10 did not have					

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 689	a risk versus benefi she given the risks a regular hamburge When interviewed of Cook-A stated they who had signed a ri for a diet upgrade, it they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Gr consistency and pa pureed food if desir When interviewed of registered dietician coughing during a ri the DON, food servi therapy. This had ri facility should not pi diet without risks be and a form signed. When interviewed of DON and RN-A stat the correct diet text swallowing problem if a resident is coug	its statement signed nor was of choking when provided with er today. on 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the s ordered and not a regular ion Form provided by Cook-A had been completed by d indicated R10 was to have a ound Meat NDD2 diet tient could downgrade to red. on 9/28/20, at 10:21 p.m. the (RD) stated if a resident were neal it should be reported to ice director and speech not been done for R10. The rovide an upgraded texture eing explained to the resident on 9/28/20, at 2:37 p.m. the ted it is important to provide ure for residents with ns. A nurse should be notified	F	589			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 31	F 6	89			
	swallowing medicat period. The MDS fu	ng during meals or when ions during the assessment rther indicated supervision, en eating and mechanically					
	indicated diagnoses and oral phase dys indicated R5 had m the evaluation had t dentures that did no without dentures, R consistency solids a Advanced. R5 was of materials into the	py Evaluation dated 1/25/19, s of cerebral infarction (stroke) ohagia. The evaluation further issing teeth, and at the time of full upper and partial lower of fit. The evaluation indicated 5 could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx,).					
	dated 1/20/20, indic mechanically altere	ent Area Worksheet (CAA) ated R5 required a d diet. There was no analysis noted to proceed to care					
	risk for nutritional a pain front thorax an diet. Staff were dire	d 3/20/20, indicated R5 was at Iteration related to chronic d diet restriction for NDD3 cted to monitor, document cian for signs or symptoms of ting.					
		dated, 1/25/19, indicated her NDD3 by Speech therapy.					
		luation dated 9/4/20, identified 03, Dysphagia Advanced diet					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI COM	E SURVEY IPLETED
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PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	R5's Care guide for and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticke Dysphagia Advance further directed to p hamburger on bun, vegetables, backed lettuce, soft ice crea During an observat R5 sat alone at a ta while she ate her m whole hamburger w covered the burger There were various area including nurs stopped to see why p.m. R5 was observ for someone get an having a seizure. S' of the dining room. When interviewed of stated R5 should have beans, potato salad should not have have have been ground a potato chips or who When interviewed of stated she has occa "spells," and has no When interviewed of Cook-A stated the f	staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, I care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw beans, no bacon, shredded am and milk. fon on 9/25/20, at 12:50 p.m. ble and was noted to cough real. R5's plate contained a with a wedge of lettuce that on a bun and potato chips. staff throughout the dining ing and dietary, but no one R5 was coughing. At 12:52 wed to be shaking and asked hurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A ave received ground meat, I, soft cooked vegetables. R5 d a bun, the burger should and should not have received de leaf lettuce. on 9/25/20, at 1:10 p.m. R5 asional seizure that are like,	F	589			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	have ground meat, For the noon meal mechanical texture ground hamburger, was the cook's resp resident is getting the When interviewed of stated staff should coughing and shou have received the of who gave her the w When interviewed of Dietary Aide-A repo- aides deliver meal the When interviewed of stated a resident is upgraded texture if been signed. The re- order from the physic and benefit form. R On 9/25/20 at 3:08 should have received not, the Cook is resp correct diet. The facility Refusal and Benefits policy resident would be in benefits of necessar opportunity regardin care. The resident of times and if resider documentation sho	no bread or hard vegetables. provided on 9/25/20, a should have included, no bun, potato salad and beans. It ponsibility to make sure a he appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ld get a nurse. R5 should correct diet and did not know rrong diet. on 9/25/20, at 1:40 p.m. orted both dietary and nursing trays. on 9/25/20, at 3:06 p.m. RN-B ok to be provided an a risk and benefit form had esident should be given the sician if there is no signed risk .5 did not have a signed form. p.m. Cook-A- stated R5 ed the ordered diet, but did sponsible for providing the of Care/Interventions, Risk dated 9/11, identified a nformed of the risk and ary care and given the ng their decision in the plan of would be approached 2-3 at continued to refuse, uld be made on the Refusal of Risk and Benefits and	F	89			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 34	F6	689			
F 725 SS=F	Dysphagia Mechan Level 1 are allowed foods may be groun no larger than one f should be easy to c Moistened ground of fish. Moist ground of with gravy or sauce pureed bread mixes and slurred breads thickness of produce products. Vegetables vegetables. Vegetable sufficient Nursing S CFR(s): 483.35(a)(1)(2)	F7	725			11/2/20
	the appropriate com provide nursing and resident safety and practicable physical well-being of each r resident assessment and considering the diagnoses of the fact accordance with the at §483.70(e). §483.35(a)(1) The f by sufficient number types of personnel of nursing care to all r resident care plans	ve sufficient nursing staff with hpetencies and skills sets to a related services to assure attain or maintain the highest l, mental, and psychosocial resident, as determined by hts and individual plans of care e number, acuity and cility's resident population in e facility assessment required facility must provide services rs of each of the following on a 24-hour basis to provide esidents in accordance with					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			C		APPROVE 0938-039
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245090	B. WING	;			_ 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 725	this section, license (ii) Other nursing p limited to nurse aid §483.35(a)(2) Exce paragraph (e) of th designate a license nurse on each tour This REQUIREME by: Based on observa review, the facility staffing to provide planned needs for R1, R3, R8, R13 a LPN-A, LPN-D, NA NA-A, RN-A, HSK- members (FM)-A, This had the poten residents. Findings include: R5's quarterly Mini included cognitivel stroke with paralys the body and a sei	ed nurses; and ersonnel, including but not les. ept when waived under is section, the facility must ed nurse to serve as a charge of duty. NT is not met as evidenced tion, interview and document failed to ensure sufficient for the individualized care 8 of 8 residents (R5, R7, R4, nd R12), 12 of 15 staff (LPN-B, A-D, NA-C, NA-J, NA-B, NA-F, A and NA-C) and 1 of 3 family reviewed for sufficient staffing. tial to affect all 42 current mum Data Set dated 9/4/20, y intact with diagnoses of is or weakness on one side of zure disorder. R5 required	F	725	F725=F. Based on observation, in and document review, the facility fe ensure sufficient staff to provide fo individualized care planned needs 8 residents, 12 of 15 staff, and 1 o family members, reviewed for suffi- staff. This has the potential to affe- current residents. Pleasant Manor has the responsib provide services by sufficient num promote resident rights and dignity. The policy in regards to completing Facility Assessment has been revi- and remains appropriate. The facility completed a facility assessment to assess and identify appropriate staffing needs for the o	ailed to r the for 8 of f 3 cient ect all 42 ility to bers to r. g a ewed	
	bathing. R5 Care Assessme 1/20/20, included, activities of daily liv and toileting.	e from staff for toileting and ent Worksheet (CAA) dated R5 extensive assistance with <i>r</i> ing (ADL) including bathing			level of care and provide guidance future staffing needs for the appro- level of care. Daily staffing assign will be signed off by Administrator Director of Nursing daily. Education will be completed with II through QAPI and with facility staff through an all-staff meeting regard	oriate ments or OT	
	needed assistance shower/bath with o	ated 8/12/20, included, R5 with toilet use and ne assist twice a week on esday evenings with skin			executed facility assessment and or review of staffing. Administrator or designee will perf audits weekly x 4 weeks, monthly	orm	

PRINTED: 11/02/2020 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00568

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDIN	G		C
		245090	B. WING			28/2020
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	=	
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 725	Continued From page 36 checks. When interviewed on 9/24/20, at 12:23 p.m. licensed practical nurse (LPN)-A stated, R5 was		F 72	months, and quarterly thereaft compliance. Audit results will b monthly at QAPI meetings for	e reviewed	
	not getting the time toileting, bathing ar	nurse (LPN)-A stated, R5 was aly care she needed with ad hygiene as there was not lid complain about this.		recommendations. Completed: 11/2/2020		
	stated, "This facility over an hour to get R5 stated it takes a the bathroom, and, Sunday and a show would rather I just t less time and effort	on 9/24/20, at 2: 20 p.m. R5 is very short staffed. I wait a nanswer to my call light." a long time to get help to go to "I should have a bath every ver every Wednesday. The aid take a shower because it takes t. Sometime, I get neither here are not enough aids on." to R5.				
	nursing assistant (I assistance with bat she had to wait for have enough staff	on 9/24/20, at 3:22 p.m. a NA)-D stated R5 required thing and toileting, but often assistance as they do not to get to everyone timely. ave to skip R5's bath as they h time.				
	licensed practical n complained of not g	on 9/24/20, at 3:45 p.m. a nurse (LPN)-B stated, R5 getting her shower on a regular osetting to her, but they were r could.				
	not receive a bath of stated, "R5's showe evening due to time did not get done du	ncern Report included, R5 did or shower on 7/22/20. NA-I er did not get done on Sunday e." NA-J stated, "R5's shower ie to running out of time. Her ids which [NA-I] and I were the				

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	only two on the floo had a lot to do and time to get in the ba another shower tha that we never got d Shower/bath record 2020: R5 received again until 8/17/20, 8/24//20. R5 received again until 9/21/20. Review of R5's cal p.m.) to 9/29/20 (2: the call light 166 tim wait time was over 41.5% of the time. R7's admission MD moderate cognitive of a stroke. R7 was required assistance transfer on and off R7's ADL (activities Rehab Care Assess dated 9/25/20, includecline in mobility, of bowel and bladdet toileting upon reque R7's care plan date required assistance dependent assist, of personal hygiene se occasionally inconti with toilet use."	or until 6 p.m. After 6 we still ended up not having enough ath R5 wanted. There was also it was supposed to get done one." ds dated July to September a shower on 7/19 but not and then not again until ed a bath on 9/13/20, but not I light log from 9/1/20 (6:53 24 p.m.), indicated, R5 used nes. Of the 166 instances, the 20 minutes on 69 occasions or eS dated 7/28/20, included impairment with a diagnosis a occasionally incontinent and by one staff person to of the toilet. of daily living)/Functional sment Area Worksheet (CAA) uded, R7 has had a recent was occasionally incontinent er, and needed assistance for	F 7	725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245090 B. WING 09/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 27 BRAND AVENUE FARIBAULT, MN 55021 5000000000000000000000000000000000000			AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
245090 B. WIND 09/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Z7 BRADD AVENUE FARIBAULT, IM 55021 (X4)[D] SUMMARY STATEMENT OF DEFICIENCES IECCH DEFICIENCY MUST BE PRECEDED BY FULL REGULATIONY OR USC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION REGULATIONY OR USC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION CROSS-REFERENCE NOT WOOD READ TO BE PROVIDE CROSS-REFERENCE NOT WOOD READ TO BE PROVIDE REFULATIONY OR USC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDE PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDE PLAN	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		PLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 55021 Image: Comparison of the state of t			245090	B. WING	i			
FARIBAULT, MN 55021 (X) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECT VAL ACTION STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECT VAL ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DEFICIENCY F 725 Continued From page 38 nursing assistant (NA)-C reported the previous week she found R7 solied halfway up her back when she started her shift. NA-C reported there was not enough staff to meet R7's toileting and hygiene needs in a timely manner. F 725 When Interviewed on 9/25/20, at 2:00 p.m. R7 was lying in bed. R7 stated, "Staffing for the facility is very bad. I blame the State because there seems to be no staffing guidelines for this facility. Call lights can go unanswered for over an hour. J push the call light when 1 need to go to the bathroom and no one comes until it is too late. I wet myself. I feel humiliated about wetting in the chair and embarrassed about needing to be cleaned up and changed." R7 looked angry, her brow was furied and her face became slightly red. R7 stated this happens at least once a week. When interviewed on 9/25/20, at 2:35 p.m. nursing assistant (NA)-D stated R7's often has to wait for assistance to the bathroom which makes her incontinent. This was always upseting to R7. Most residents wait for an extended period of time to receive an answeret AD-D stated that there have been, "Too many times," at the beginning of the shift when several residents are solied and need assistance. NA-D stated the	NAME OF F	PROVIDER OR SUPPLIER			2,	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT DEFICIENCY F 725 Continued From page 38 nursing assistant (NA)-C reported the previous week she found R7 solied halfway up her back when she started her shift, NA-C reported there was not enough staff to meet R7's toileting and hygiene needs in a timely manner. F 725 When Interviewed on 9/25/20, at 2:00 p.m. R7 was lying in bed. R7 stated, "Staffing for the facility is very bad. I blame the State because there seems to be no staffing guidelines for this facility. Call lights can go unanswered for over an hour. I push the call light when I need to go to the bathroom and no one comes until it is too late. I wet myself. I feel humilitated about wetting in the chair and embarrassed about needing to be cleaned up and changed." R7 looked angry, her brow was furled and her face becames slightly red. R7 stated this happens at least once a week. When interviewed on 9/25/20, at 2:35 p.m. nursing assistant (NA)-D stated R7's often has to wait for assistance to the bathroom which makes her incontinent. This was always upsetting to R7. Most residents wait for an extended period of time for the call light. NA-D has assisted R7 after R7 was incontinent secondary to waiting for a prolonged period of time for the call light when several residents are solied and need assistance. NA-D stated the	PLEASA	NT MANOR LLC						
 nursing assistant (NA)-C reported the previous week she found R7 soiled halfway up her back when she started her shift. NA-C reported there was not enough staff to meet R7's toileting and hygiene needs in a timely manner. When Interviewed on 9/25/20, at 2:00 p.m. R7 was lying in bed. R7 stated, "Staffing for the facility is very bad. I blame the State because there seems to be no staffing guidelines for this facility. Call lights can go unanswered for over an hour. I push the call light when I need to go to the bathroom and no one comes until it is too late. I wet myself. I feel humiliated about wetting in the chair and embarrassed about needing to be cleaned up and changed." R7 looked angry, her brow was furled and her face became slightly red. R7 stated this happens at least once a week. When interviewed on 9/25/20, at 2:35 p.m. nursing assistant (NA)-D stated R7's often has to wait for assistance to the bathroom which makes her incontinent. This was always upsetting to R7. Most residents wait for an extended period of time to receive an answer to their call light. NA-D has assisted R7 after R7 was incontinent secondary to waiting for a prolonged period of time for the call light to be answered. NA-D stated that there have been, "Too many times," at the beginning of the shift when several residents are soiled and need assistance. NA-D stated the 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
one licensed practical nurse (LPN) or registered nurse (RN) for the 42 current residents in the facility. When interviewed on 9/25/20, at 2:55 p.m. LPN-D stated there was insufficient staff to meet	F 725	nursing assistant (N week she found R7 when she started h was not enough sta hygiene needs in a When Interviewed of was lying in bed. R facility is very bad. I there seems to be n facility. Call lights ca hour. I push the cal bathroom and no of wet myself. I feel h chair and embarras cleaned up and cha brow was furled and R7 stated this happ When interviewed of nursing assistant (N wait for assistance her incontinent. Thi Most residents wait time to receive an a has assisted R7 aft secondary to waitin time for the call light that there have bee beginning of the shi soiled and need assi night shift is custom one licensed praction nurse (RN) for the call when interviewed of the shift is custom one licensed praction nurse (RN) for the call when interviewed of the shift is custom one licensed praction nurse (RN) for the call soiled and need assi night shift is custom one licensed praction nurse (RN) for the call facility.	A)-C reported the previous soiled halfway up her back er shift. NA-C reported there off to meet R7's toileting and timely manner. on 9/25/20, at 2:00 p.m. R7 7 stated, "Staffing for the I blame the State because ho staffing guidelines for this an go unanswered for over an I light when I need to go to the ne comes until it is too late. I umiliated about wetting in the used about needing to be anged." R7 looked angry, her d her face became slightly red. then at least once a week. on 9/25/20, at 2:35 p.m. NA)-D stated R7's often has to to the bathroom which makes s was always upsetting to R7. for an extended period of answer to their call light. NA-D er R7 was incontinent g for a prolonged period of at to be answered. NA-D stated an, "Too many times," at the iff when several residents are sistance. NA-D stated the harily staffed with two NA's and cal nurse (LPN) or registered 42 current residents in the	F	725	5		

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
тад F 725	Continued From par morale among staff of this. R7's call light respond 9/22/20, at 3:51 a.m. showed the call light the seven day period initiated, 11 (or 21.5 15 minutes to receind 14%) of these alerts to receive a respond R4's admission Min 6/29/20, included, m with diagnoses included, m with diagnoses included, m with diagnoses included, m with diagnoses included, m was occasionally in times during the as R4's incontinence C dated 7/1/20 indicat urinary incontinence assistance with toile incontinence." "She and OT [occupation the goal of returning uses incontinence period	ge 39 f and residents is low because onse time logs dated from n. to 9/28/20, 9:25 a.m. at was engaged 51 times over od. Of the 51 call light alerts 5%) of these alerts took over ve a response. Seven (or s took longer than 20 minutes se. himum Data Set (MDS) dated noderate cognitive impairment uding diabetes, dementia and ed extensive assistance with assistance with personal ot on a toileting program and continent of urine (less than 7 sessment period). Care Area Assessment (CAA) ted, "Resident triggers for e r/t [related to] need for	1	225		RIATE	DATE
	included severe cog dependent upon sta hygiene and was al	nge MDS dated 8/27/20, gnitive impairment, was totally aff for toileting and personal ways incontinent of urine. CAA dated 8/28/20 included,					

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		AND HUMAN SERVICES				FORM	: 11/02/2020 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING	;			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	 "Resident triggers f toilet use and bladd declined in both mo She has recently er life cares. Resident aid in keeping skin current toileting pla [every] AM [morning incontinent episode R4's only Bowel and medical record was R4 was continent o R4's care plan date "Alteration with elimito, "Assist of 1 with not been updated s 8/27/20, MDS noted incontinence to total in assistance needs hygiene. R4's nursing assistants assistance needs hygiene. R4's nursing assistants toileting needs. During continuous of starting at 10:34 a.r if she would like to declined. No encou provided. No additio incontinence cares licensed practical n her room to check I insulin. LPN-D then 	for urinary incontinence r/t der incontinence. Resident has obility and cognitive function. nrolled in hospice for end of t uses incontinence products to dry. Plan to continue to with in and complete peri cares q g], HS [night], and with each	F	725	,		

Facility ID: 00568

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING	·			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	1:58 p.m. NA-F and and changed R4's w When interviewed of and NA-B stated th morning cares at 7: not had time to ass since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge without being assis When interviewed of director of nursing of should be assisted hours. The DON si needs very well. Re was present review and Bladder assess 6/24/20, noting it in bladder. RN-A revi identified R4 had no Bladder assessment significant decline in June of 2020. RN- an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least ev R4's call light log from R4 used the call lig- instances the wait to	A NA-B assisted R4 into bed visibly wet brief. on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or toilet of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. on 9/28/20, at 3:05 p.m. the DON) stated, she thought R4 with incontinent cares every 2 tated she did not know R4's egistered nurse (RN)-A who ved R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and of had an updated Bowel and nt, even though she had a in condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4 checked for incontinence and very 2 hours. om 9/1/20 - 9/29/20 revealed ht 20 times. Of the 20 ime was over 10 minutes on r 40 minutes on one occasion,	F	725			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED					
		245090	B. WING			C 09/28/2020						
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE								
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE					
F 725	Continued From pa	ge 42	F7	725								
	8/20/20, included, s with diagnoses incluinjury) and dementia assistance with mose (ADL's) and did not falls with injury since had a discharge ME R1's care plan date AEB [as evidenced admission related to secondary to TBI ar disturbances." The "Resident will be sa should incident occo "Provide one on one and wheeling her do The facility provided from 7/21/20 thorou R1 had fallen in the frame. 7/14/20, 7/3 8/11/20, 8/12/20, 8/ 9/14/20 and 9/15/20 Hospital discharge s indicated R1 was tra 9/15/20 after sustain agitation. Summary fractured skull and to R1's progress notes revealed:	ed 9/2/20, included, "Fall risk by] multiple falls since o lack of safety awareness and Dementia with behavioral e goal for R1 was listed as, afe and free from serious injury ur." Staff were directed to, e care, such as taking outside own the hall." d a running list of R1's falls ugh 9/24/20, which indicated e facility 17 times in that time 81/20, 8/1/20, 8/5/20, 8/6/20, 12/20, 8/16/20, 8/16/20, 21/20, 8/29/20, 9/3/20, 0. summary dated 9/16/20, ansferred to the hospital on ning a fall related to increased y details R1 incurred a										

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245090	B. WING	i			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	R1's progress note included R1 had att several times after Facility transferred started to yell out at and back. R1 repor neck and back. R1 wheelchair. Facility ratio as the facility of R1's physician was confirmed for the R hospital. R1's guard transfer situation. R1's progress note included, R1 was tra- full report was given teams. The floor nu inform that R1 was safety concerns. R1's progress noted included, R1 was tra- full report was given teams. The floor nu inform that R1 was safety concerns. R1's progress noted included, R1 was no marked behaviors: put herself onto the louder than her usu and 1:1, 2:2, 3:3 we remained aggressiv 911 to send R1 to e for further evaluatio When interviewed of stated there were ti one attention, but th cover a unit of 30 re possible. When interviewed of	nge 43 dated 9/16/20, at 5:35 p.m. tempted to crawl out of bed returning from the hospital. R1 to her wheelchair, R1 then nd reported of pain in neck ted to facility of pain in her started to stand up from her initiated a 2 to 1 staff to R1 determined R1 was not safe. contacted and consulted and 1 to be sent back to the dian was informed of the dated, 9/16/20, at 6:24 p.m. ansferred back the hospital. A n to the police and transport arse called the hospital to returning to them due to d dated 9/16/20, at 6:28 p.m. oted to have continued swore at staff, attempted to e floor, yelling and hollering ial, R1 was extremely agitated ere attempted and R1 ve towards staff. Facility called emergency department (ED) on per physician's orders. on 9/24/20, at 1:00 p.m. NA-B mes when R1 required one on hey only had one or two staff to esidents, so this was not	F 7	725			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245090	B. WING _				28/2020
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				' BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725		e fell a lot. on 9/24/20, at 2:56 p.m. the	F 72	25			
	would not take R1 t they did not have en enough.	ocial worker stated the facility back to the facility because nough help to watch her well					
	stated R1 required time to prevent her not have the time to NA-D stated she wo	on 9/24/20, at 3:22 p.m. NA-D a significant amount of staff from falling and they just did o stay with her all the time. orked the day shift and often er shift would find R1, "sopping tent brief.					
	stated there was no	on 9/24/20, at 3:45 p.m. LPN-B ot enough staffing to supervise afe as she required individual					
	DON stated due to could not be met at	on 9/28/20, at 10:10 a.m. the limited staffing R1's needs the facility, therefore R1 could fter her last admission to the					
	8/15/20, revealed R impairment. R3 req staff physical assist diagnosis included swallowing concern mouth when eating mouth/cheeks or re	imum data set (MDS), dated 3 had moderate cognitive uired supervision and one cance for eating. R1's a stroke. R3 had the following us: loss of liquids/solids from or drinking, holding food in sidual food in mouth after ag during meals or when					

Facility ID: 00568

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391				
STATEMENT AND PLAN O	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C						
		245090	B. WING				_ 28/2020				
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE								
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE				
F 725	Continued From pa swallowing medicat	•	F7	725							
	staff, "The resident with adequate eatin all meals in the dini	updated 9/24/20, directed needs a calm, quiet meal time of time. The resident requires ng room r/t [related to] close eceive meals until supervision									
	stated she worked of "understaffed." NA be provided mornin especially if they re- assistance with me- required individual a not eat too quickly of get enough fluid. NA	on 9/24/20, at 12:56 p.m. NA-A day shift and considered it, -A reported residents waited to og cares prior to breakfast, quired two staff and chanical lift. NA-A stated, R3 assistance for cueing him to or take too big of a bite and to A-A noted R3 often had to wait eat until they had enough staff to help him.									
	stated, R3 required make sure he ate th staff were available	on 9/24/20, at 3:22 p.m. NA-D staff to closely monitor to he amount he should. Often no to help, he would sit and look vaiting for his plate of food.									
	stated, there were s assistance in the di to figure out how to entire time due to c	on 9/24/20, at 3:45 p.m. LPN-B several residents that required ning room and it was difficult feed R3. R3 required help the hoking precautions and the entire meal time.									
	wheeled self into th wheel chair back ar	on 9/25/20, at 12:21 p.m. R3 e dining room. R3 rolled his nd forth at the table, looking al was brought to him at 12:41									

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						(X3) DATE SURVEY COMPLETED	
-			A. BUILD	ING	3		C
		245090	B. WING				28/2020
NAME OF F	PROVIDER OR SUPPLIER	•		Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE		
					FARIBAULT, MN 55021		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	^	CROSS-REFERENCED TO THE APPROPR		DATE
					DEFICIENCY)		
F 705		40					
F 725	Continued From pa	ge 46	F 7	25	5		
	When interviewed o	on 9/25/20, at 1:21 p.m. NA-F					
		er enough staff in the dining					
	room to feed every	one. "On a good day, we are					
	lucky to have 2 aide	es to assist all the residents."					
	R8's admission MD	S, dated 8/10/20, included, R8					
		ct with a diagnosis of					
		e. R8 required physical					
		f for transfers and supervision					
	and one person phy	vsical assistance for toileting.					
	R8's care plan, last	revised 8/24/20, directed					
		elimination r/t [related to]					
		Assist of 1 with toileting as					
	needed for hygiene	."					
	When interviewed o	on 9/24/20, at 12:23 p.m.					
		as independent with cares in					
	the morning and ne	eded more assistance in the					
		oted R8 might not even turn					
	her call light on but	noller out for staff.					
	When interviewed of	on 9/24/20, at 12:56 p.m. NA-A					
		touch base," with R8 as she is					
		and staff need to help with					
	residents who requi	ired more assistance.					
	When interviewed o	on 9/28/20, at 10:37 a.m. R8					
		ot enough staff to help her					
	when she needed it	t. R8 stated she has problems					
		ecreased ability to do things					
		er Parkinson's medication was ff tell her they have a half hour					

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PRINTED: 11/02/2020

		AND HUMAN SERVICES	1			FORM	11/02/2020 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COM	E SURVEY PLETED C
		245090	B. WING				28/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	on each side of the but it is often over the they do not have en- time. R8 stated she the bathroom, she of minutes to get on o her back to hurt and unable to care for h R8's medication add dated August 2020, Carbidopa-Levodop Parkinson's disease stiffness, tremors, s control) five times of 4:00 p.m., 7:30 p.m. noted as being adm each opportunity, binot not noted. When interviewed of LPN-D stated R8 w time. LPN-D stated getting her medicat R8's call light log, d included, R13 activative two incidents, the re and 40 minutes. On time was between 4 incident, the respon- minutes. R13's quarterly MD cognitively intact wi sclerosis. R13 requires and the state of the state of the state of the state of the state of the state of the sclerosis. R13 requires and the state of the state of the sclerosis. R13 requires and the state of the sclerosis. R13 requires and the sclerosis. R13 requires and the state of the state of the sclerosis. R13 requires and the state of the state of the sclerosis. R13 requires and the state of the state of the state of the sclerosis. R13 requires and the state of the st	time her medication is due, hat. R8 stated staff tell her nough staff to get it to her on e does not get enough help to often has to wait 20-40 r off the toilet. This causes d she gets even more still and herself even more. ministration record (MAR), included an order for ba (a medication for treating e symptoms such as muscle spasms, and poor muscle daily; 5:55 a.m., 10:00 a.m., h. and 11:30 p.m. R8 was hinistered the medications at ut the time administered was on 9/28/20, at 10:58 a.m. ranted her medications on d R8 reported concerns with ions on time in the evening. ated 9/8/20 through 9/25/20, ated her call light 12 times. On esponse time was between 30 n two incidents the response 40 and 50 minutes. On one has time was over 100 S dated 9/18/20, included th a diagnosis of multiple uired two staff for toileting and	F 7	725			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	risk for skin breakd assistance. The ca call light in reach ar When interviewed of stated R13 was tota cares. Sometimes F breakfast as they di her up before break up, but is agreeable Often R13 would be were able to attend When interviewed of stated when coming they would find R13 often the only staff competent to use th get R13 up, and du in bed at supper tim they just didn't have her up. When interviewed of stated she is incont medical condition, s periods of time to b In addition, she ofte because there is no This was upsetting R13's call light logs reviewed. R13's cal 10 and 20 minutes 30 and 40 minutes between 40 and 50 between 50 and 60	own and required staff ire plan indicated to keep the nd answer promptly. on 9/24/20, at 1:31 p.m. NA-C ally dependent on staff for R13 had to stay in bed for idn't have enough staff to get (fast. R13 would prefer to get e when they need her to be. e, "saturated" by the time they to her after breakfast. on 9/24/20, at 3:22 p.m. NA-D g on for the afternoon shift 8 soaked in urine. NA-D was on afternoons who was ne mechanical lift needed to e to this, often R13 had to stay ne. This would upset R13, but e enough help to always get on 9/28/20, at 11:05 a.m. R13 inent of urine due to her she often has to wait extended e changed in order to be dry. en is unable to get out of bed of enough staff to help her up.	F 7	725			

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		245090	B. WING				C 28/2020				
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE							
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE				
F 725	Continued From pa	ge 49	F 7	25							
	R12 had moderate was on hospice ser care. R12's diagnos disease, asthma/ch disease or chronic failure.	S dated 8/14/20, included, cognitive impairment. R12 vices and required oxygen ses included coronary artery ironic obstructive pulmonary lung disease and respiratory									
	report (MAR/TAR), staff, "Connect 02 bedtime." and "Oxy cannula while at re- marked as complet 9/17/20. The MAR/ has bipap on every cpap placement. Pl every hour overnigh completed on 9/4/2 "Bipap-Nurse must sleeping and at nig completed the nigh	put on use daily when ht." This was not marked as t of 9/4/20 and 9/17/20.									
	family had concern	p.m. LPN-B stated, R12's and s about staffing. LPN-B R12 "needier," than other									
	R12, (FM)-A stated through video. R12 and oxygen nasal of assist with respirato would notice times not applied, or not a amounts of time, no 3:20 a.m. to 3:50 a	9 a.m. a family member of she monitored R12's care wore a bipap mask at night annula during the day to ory and breathing issues. FM-A R12's bipap or oxygen was applied properly for significant oting recent example between .m.; 5:00 a.m. to 7:10 a.m., :17 a.m. on 9/24/20. FM-A									

Facility ID: 00568

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		AND HUMAN SERVICES					FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	0	(X3) DATI COM	E SURVEY PLETED
		245090	B. WING _					C 28/2020
NAME OF F	PROVIDER OR SUPPLIER	-		STF	REET ADDRESS, CITY, STATE, ZIF	2 CODE		
				27 I	BRAND AVENUE			
PLEASA	NT MANOR LLC			FA	RIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
TAG F 725	Continued From par reported, during the the facility to alert s the interview, R12 r when she was not g needed, like she was R12 was deterioration physically and was the oxygen. FM-A s she noted no came movement detected 11:34 p.m. and 4:05 required frequent m was on properly. FM she felt like a burder had informed the di concerns and there improvement. R12's call light log, included, R12 active Eleven of those we minutes. Six were a minutes.	ge 50 ese instances, she would call taff, without response. During noted she did not feel well getting the oxygen she as in a "daze". FM-A reported ing both cognitively and more confused when not on tated, on 9/18/20 to 9/19/20 ra activity, indicating no d, in R12's room between D p.m. FM-A noted R12 nonitoring to ensure her bipap M-A reported R12 had told her en to staff. FM-A reported she rector of nursing of her was no resolution or dated 9/1/20 to 9/29/20, ated the call light 66 times. re answered in 10 to 20 answered between 20 to 30 answered between 30 to 40 answered between 40 and 50 answered in over 60 minutes on 9/24/20, at 12:23 p.m. were not enough staff to care A explained there were e aide on west side of the care were not getting the timely care mely toileting, bathing and burnout and turnover. LPN-A cussed concerns with DON ind there had been no eported she helped the	F 72	25				
	resolution. LPN-A render nursing assistants v							

Facility ID: 00568

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED				
		245090	B. WING				_ 28/2020				
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE								
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE				
F 725	medication pass for there was an overa getting the timely as hygiene. When interviewed of reported she was p assistant duties to h appointments and w sufficient nursing st peri-cares for reside busy with their own time baths and sho residents were not evening cares when chart a resident refu- had not been offere bathed, when they been reported to be with no changes. When interviewed of stated she worked to times when she wo building. Resident extended periods of hour. They just cou- meal times resident "Short staffing is a of been reported to the there was nothing to When interviewed of stated there was or residents. Nurses of addition to their reg- were not able to mat-	ge 51 r residents. LPN-A reported II concern with resident not ssistance with bathing and on 9/24/20, at 1:31 p.m. NA-C ulled away from her nursing help with electronic medical wound rounds. There was not aff to provide oral care and ents. The nurses were too duties to assist. Most of the wers were missed and assisted with morning and in they preferred. Staff would used a bath, when the resident ed, or chart a resident was were not bathed. This had oth the DON and administrator on 9/24/20, at 3:22 p.m. NA-D the night shift and there were uld be the only nurse aid in the call lights were on for f time- sometimes over an uld not get to them timely. At ts complain of cold food. daily occurrence." This had e administrator but was told hey could do about it. on 9/24/20, at 3:45 p.m. LPN-B he or two aides for 30 were expected to provide 5 residents each shift in ular duties. Sometimes, they ake sure resident treatments /hen staff come from a	F	725							

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		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245090	B. WING				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	they do not have en their work. LPN-B I management and w When interviewed of HSK-A stated nursi "burned out," becau time to meet reside When interviewed of administrator, assis RN-A were interview facility assessment staffing needs to m needs. Typically, th assistant per 10 res were residents who wait times, particula "The staff have may noticed "a lot of sta administrator noted dynamics and cultu staffing concerns. T was committed to in and chipping in with she felt there was a but felt the commun reported there was too many staff and reported there was census was down. The facility staffing staff, "Our facility po staff with the skills a provide care ad ser accordance with res	y are reluctant to return as nough time to complete all of nad reported this concern to vas told they had enough staff. on 9/25/20, at 11:12 p.m. ng assistance seem to be, use they do not have enough nt needs. on 9/28/20, at 3:36 p.m. the tant administrator, DON and wed together. There was no to determine the specific eet resident care planned here should be 1 nursing sidents. DON stated there complained about call light arly at night time. RN-A stated, de it seem so drastic" but	F 7	725			

Facility ID: 00568

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		E SURVEY IPLETED
D PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		C
		245090	B. WING _			28/2020
AME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		
LEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 725		ect care staff are determined residents based on each	F 72	25		
F 805 SS=D	Food in Form to Me	et Individual Needs	F 80	05		11/2/20
	§483.60(d) Food ar Each resident recei	nd drink ves and the facility provides-				
	to meet individual n	prepared in a form designed eeds. NT is not met as evidenced				
	review, the facility factorial accordance with res	ion, interview, and document ailed to prepare food in sidents needs for 2 of 3 R10) reviewed who required ets.		F805=D. Based on observation interview, and document review facility failed to prepare food in accordance with residents nee 3 residents reviewed and requi modified texture diets.	w, the ds for 2 of	
		S dated 7/14/20, included		Pleasant Manor residents have receive food prepared in a forr to meet their individual needs.	n designed Pleasant	
		th diagnoses of diabetes and required supervision and set eating.		Manor staff have a responsibil monitor and ensure that the re receive food prepared in a forr their individual needs.	sidents	
R10's Speech Therapy evaluation dated 3/26/20, included a diagnosis of pharyngeal phase dysphagia (difficulty swallowing for issues in the throat) and oral phase dysphagia (due to issues in the mouth). The evaluation noted R10 was at risk for aspiration of food or fluids. Recommendations were made for puree		The associated policies related appropriate diet texture have b reviewed and remain appropria All residents diet textures were and remain appropriate. All ph orders match culinary meal ca Education was provided to all s	een ate. reviewed nysician rd system.			
	consistency, small l (chewing), swallow bite/sip, slow pacing between liquids/soli	bites thorough mastication bites before taking another g, single sips, alternate ids. The report indicated uld be required to determine if		regarding serving appropriate diet textures during meal time. Culinary Director/Dietitian or do perform audits weekly x 4 wee x 3 months, and quarterly there	modified esignee will ks, monthly	

Facility ID: 00568

If continuation sheet Page 54 of 61

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245090	B. WING			C 28/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 805	Continued From pa	qe 54	F 805	5		
		opriate for diet upgrade.		ensure compliance. Audit results w reviewed monthly at QAPI meeting		
	identified a risk fact	atus CAA dated 4/10/20, or of a mechanically altered f this risk factor was		further recommendations. Completed 11/2/2020		
	nutritional alteration meals; had diet res [National Dysphagia ground or are minc pieces, they are mo and could have req directed to monitor,	ed 4/1/20, included, risk for a related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be ed no larger than 1/4 inch bist, with some cohesion] diet uested puree. Staff were document, and report to the d for signs and symptoms of is.				
		ing assistant Care Guide al soft diet with pureed meat.				
	identified a mechar meat. Speech ther	luation dated 4/16/20, hical soft diet with pureed apy recommended to, "have nless resident request pureed				
		Evaluation dated 7/14/20, full upper and lower dentures.				
	was observed to be 12:47 p.m. it was no hamburger patty or hard to eat because dentures in. She ha as the staff had gril desired one. R10 c	on 9/25/20, at 12:42 p.m. R10 e coughing while eating. At oted R10 was eating a regular a bun. R10 stated it was e she did not have her ad requested the regular patty led out the burgers and she continued to cough while cked to see if she was alright,				

If continuation sheet Page 55 of 61

		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 805	Continued From pa	-	F٤	305			
	nor did anyone brin	g her dentures.					
	texture and to provi	ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded					
	aide (DA)-A stated mechanical soft die	on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating.					
	(CK)-A stated, a me ground meat, no br	on 9/25/20, at 1:12 p.m. cook echanical soft diet should have ead or hard vegetables. The responsible to ensure the ed.					
	stated R10 does co unaware R10 did no stated if someone is	on 9/25/20, at 1:21 p.m. NA-F ough at meals, she was ot have dentures in. NA-F s coughing like that, they se to assess if no nurse was					
	stated she normally today got a regular grilling them. R10 s dentures, but forgot have to remind her	on 9/25/20, at 1:34 p.m. R10 / gets a ground burger, but whole burger as they were stated she normally wore her t them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H as ok.					
	stated resident's die wished for an upgra	on 9/25/20, at 3:06 p.m. RN-B ets could be upgraded if they ade, but would have to sign a s statement. R10 did not have					

If continuation sheet Page 56 of 61

		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 805	a risk versus benefi she given the risks a regular hamburge When interviewed of Cook-A stated they who had signed a ri for a diet upgrade, it they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Gr consistency and pa pureed food if desir When interviewed of registered dietician coughing during a ri the DON, food servi therapy. This had ri facility should not pi diet without risks be and a form signed. When interviewed of DON and RN-A stat the correct diet text swallowing problem if a resident is coug	its statement signed nor was of choking when provided with er today. on 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the s ordered and not a regular ion Form provided by Cook-A had been completed by d indicated R10 was to have a ound Meat NDD2 diet tient could downgrade to red. on 9/28/20, at 10:21 p.m. the (RD) stated if a resident were neal it should be reported to ice director and speech not been done for R10. The rovide an upgraded texture eing explained to the resident	F	805			

If continuation sheet Page 57 of 61

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASANT MANOR LLC					7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 805	Continued From pa	-	F٤	05			
	swallowing medicat period. The MDS fu	ng during meals or when ions during the assessment irther indicated supervision, en eating and mechanically					
	indicated diagnoses and oral phase dys indicated R5 had m the evaluation had t dentures that did no without dentures, R consistency solids a Advanced. R5 was of materials into the	py Evaluation dated 1/25/19, s of cerebral infarction (stroke) phagia. The evaluation further issing teeth, and at the time of full upper and partial lower of fit. The evaluation indicated 5 could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx,)					
	dated 1/20/20, indic mechanically altere	ent Area Worksheet (CAA) ated R5 required a d diet. There was no analysis noted to proceed to care					
	risk for nutritional a pain front thorax an diet. Staff were dire	d 3/20/20, indicated R5 was at lteration related to chronic d diet restriction for NDD3 cted to monitor, document cian for signs or symptoms of ting.					
		dated, 1/25/19, indicated her NDD3 by Speech therapy.					
		lluation dated 9/4/20, identified D3, Dysphagia Advanced diet					

If continuation sheet Page 58 of 61

		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 805	R5's Care guide for and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticke Dysphagia Advance further directed to p hamburger on bun, vegetables, backed lettuce, soft ice crea During an observat R5 sat alone at a ta while she ate her m whole hamburger w covered the burger There were various area including nurs stopped to see why p.m. R5 was observ for someone get an having a seizure. S' of the dining room. When interviewed of stated R5 should have beans, potato salad should not have have have been ground a potato chips or who When interviewed of stated she has occa "spells," and has no When interviewed of Cook-A stated the f	 staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, d care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw beans, no bacon, shredded am and milk. ion on 9/25/20, at 12:50 p.m. able and was noted to cough neal. R5's plate contained a <i>v</i>ith a wedge of lettuce that on a bun and potato chips. staff throughout the dining ing and dietary, but no one R5 was coughing. At 12:52 wed to be shaking and asked nurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A ave received ground meat, d, soft cooked vegetables. R5 d a bun, the burger should and should not have received ple leaf lettuce. on 9/25/20, at 1:10 p.m. R5 asional seizure that are like, 	F	305			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 805	have ground meat, For the noon meal mechanical texture ground hamburger, was the cook's resp resident is getting the When interviewed of stated staff should coughing and shou have received the of who gave her the w When interviewed of Dietary Aide-A repo- aides deliver meal the When interviewed of stated a resident is upgraded texture if been signed. The re- order from the physic and benefit form. R On 9/25/20 at 3:08 should have received not, the Cook is resp correct diet. The facility Refusal and Benefits policy resident would be in benefits of necessar opportunity regardin care. The resident of times and if resider documentation sho	no bread or hard vegetables. provided on 9/25/20, a should have included, no bun, potato salad and beans. It ponsibility to make sure a he appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ld get a nurse. R5 should correct diet and did not know wrong diet. on 9/25/20, at 1:40 p.m. orted both dietary and nursing trays. on 9/25/20, at 3:06 p.m. RN-B ok to be provided an a risk and benefit form had esident should be given the sician if there is no signed risk to did not have a signed form. p.m. Cook-A- stated R5 ed the ordered diet, but did sponsible for providing the I of Care/Interventions, Risk dated 9/11, identified a nformed of the risk and ary care and given the ng their decision in the plan of would be approached 2-3 nt continued to refuse, puld be made on the Refusal of Risk and Benefits and	F 8	05			

If continuation sheet Page 60 of 61

		AND HUMAN SERVICES				FORM	11/02/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>·</i>		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 805	Continued From pa	ge 60	F٤	805			
	Dysphagia Mechan Level 1 are allowed foods may be groun no larger than one is should be easy to of Moistened ground of fish. Moist ground with gravy or sauce pureed bread mixes and slurred breads thickness of produce products. Vegetables	hagia Diet indicated NDD2 as ically Altered. All foods on the dor minced into small pieces forth inch. All food items thew. Meats should be for cooked meat, poultry, or or tender meat may be served that are gelled through entire at and to avoid all other bread es should be soft, well-cooked ables should be less than 1/2 easily mashed with a fork.					

If continuation sheet Page 61 of 61



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 25, 2020

Administrator Pleasant Manor LLC 27 Brand Avenue Faribault, MN 55021

Re: Reinspection Results Event ID: 2XHN11

Dear Administrator:

On November 19, 2020 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 September 28, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kumalu Fishe Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: kamala.fiske-downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 13, 2020

Administrator Pleasant Manor LLC 27 Brand Avenue Faribault, MN 55021

Re: State Nursing Home Licensing Orders Event ID: 2XHN11

Dear Administrator:

The above facility was surveyed on September 24, 2020 through September 28, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Pleasant Manor LLC October 13, 2020 Page 2

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:

Karen Aldinger, Unit Supervisor Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: karen.aldinger@state.mn.us Office: (651) 201-3794 Mobile: (320) 249-2805

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

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

Please feel free to call me with any questions.

Sincerely,

Kumalu Fishe Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

Minneso	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00568	B. WING		09/2	2 8/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		DAVENUE LT, MN 5502	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	survey was conduct with State Licensure NOT in compliance Please indicate in y correction that you and identify the date	S: and 9/28/20, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(x6) date 10/30/20

Electronically Signed

STATE FORM

If continuation sheet 1 of 49

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED
		00568	B. WING			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 5502	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED H5090056C: MN Ru H5090057C MN Ru Rule 4658.0525 Su H5090059C MN Ru	laints were found to be with a licensing order issued: ule 4658.0520 Subp. 1 Ile 4658.0510 Subp. 1 and MN bp. 6 B Ile 4658.0510 Subp. 1; MN bp. 6 B.; and MN Rule				
	unsubstantiated: H	laints were found to be 5090055C and H5090058C ed in ePOC and therefore a uired at the bottom of the first				
2 800	MN Rule 4658.0510 Staffing requiremen) Subp. 1 Nursing Personnel; its	2 800			11/2/20
	home must have or number of qualified registered nurses, li nursing assistants t residents at all nurs in all buildings if mo	requirements. A nursing a duty at all times a sufficient nursing personnel, including icensed practical nurses, and o meet the needs of the ses' stations, on all floors, and ore than one building is ides relief duty, weekends, iements.				
	by: Based on observati review, the facility fa staffing to provide fo planned needs for 8 R1, R3, R8, R13 an	ent is not met as evidenced on, interview and document ailed to ensure sufficient or the individualized care 3 of 8 residents (R5, R7, R4, id R12), 12 of 15 staff (LPN-B, -D, NA-C, NA-J, NA-B, NA-F,		Area Acknowledged		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00568	B. WING			C 09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 800	Continued From pa	ge 2	2 800				
	members (FM)-A,	A and NA-C) and 1 of 3 family reviewed for sufficient staffing. ial to affect all 42 current					
	Findings include:						
	included cognitively stroke with paralysi the body and a seiz	num Data Set dated 9/4/20, r intact with diagnoses of s or weakness on one side of cure disorder. R5 required from staff for toileting and					
	1/20/20, included,	ent Worksheet (CAA) dated R5 extensive assistance with ing (ADL) including bathing					
n s c V li n t	needed assistance shower/bath with or	ated 8/12/20, included, R5 with toilet use and ne assist twice a week on esday evenings with skin					
	licensed practical n not getting the time toileting, bathing an	on 9/24/20, at 12:23 p.m. urse (LPN)-A stated, R5 was ly care she needed with id hygiene as there was not id complain about this.					
	stated, "This facility over an hour to get R5 stated it takes a the bathroom, and, Sunday and a show would rather I just t	on 9/24/20, at 2: 20 p.m. R5 r is very short staffed. I wait an answer to my call light." long time to get help to go to "I should have a bath every ver every Wednesday. The aid ake a shower because it takes . Sometime, I get neither					

	NT OF DEFICIENCIES	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
						С
		00568	B. WING		09/2	28/2020
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE ILT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 3	2 800			
	This was upsetting	to R5.				
	nursing assistant (N assistance with bath she had to wait for a have enough staff to	on 9/24/20, at 3:22 p.m. a IA)-D stated R5 required ning and toileting, but often assistance as they do not o get to everyone timely. ve to skip R5's bath as they n time.				
	When interviewed on 9/24/20, at 3:45 p.m. a licensed practical nurse (LPN)-B stated, R5 complained of not getting her shower on a regular basis. This was upsetting to her, but they were doing the best they could.					
	not receive a bath of stated, "R5's showe evening due to time did not get done due bath requires two ai only two on the floo had a lot to do and time to get in the ba	ncern Report included, R5 did or shower on 7/22/20. NA-I er did not get done on Sunday e." NA-J stated, "R5's shower e to running out of time. Her ids which [NA-I] and I were the r until 6 p.m. After 6 we still ended up not having enough th R5 wanted. There was also t was supposed to get done one."				
	2020: R5 received again until 8/17/20,	Is dated July to September a shower on 7/19 but not and then not again until ed a bath on 9/13/20, but not				
	p.m.) to 9/29/20 (2:2 the call light 166 tim	light log from 9/1/20 (6:53 24 p.m.), indicated, R5 used nes. Of the 166 instances, the 20 minutes on 69 occasions or				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00568	B. WING			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 4	2 800			
	moderate cognitive of a stroke. R7 was required assistance	R7's admission MDS dated 7/28/20, included moderate cognitive impairment with a diagnosis of a stroke. R7 was occasionally incontinent and required assistance by one staff person to transfer on and off of the toilet.				
	Rehab Care Assessment Area Worksheet (CAA) dated 9/25/20, included, R7 has had a recent decline in mobility, was occasionally incontinent of bowel and bladder, and needed assistance for toileting upon request.					
	required assistance dependent assist, d personal hygiene se	d 7/29/20, included, R7 e for, "Bathing with max to Iressing with max assist, et-up with minimal assist, inent, and requires assistance				
	nursing assistant (N week she found R7 when she started h	on 9/24/20, at 1:31 p.m. a NA)-C reported the previous soiled halfway up her back er shift. NA-C reported there iff to meet R7's toileting and timely manner.				
	was lying in bed. R facility is very bad. I there seems to be r facility. Call lights ca hour. I push the cal bathroom and no or wet myself. I feel h chair and embarras cleaned up and cha brow was furled and	on 9/25/20, at 2:00 p.m. R7 7 stated, "Staffing for the I blame the State because no staffing guidelines for this an go unanswered for over an I light when I need to go to the ne comes until it is too late. I umiliated about wetting in the seed about needing to be anged." R7 looked angry, her d her face became slightly red. pens at least once a week.				

If continuation sheet 5 of 49

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00568	B. WING			C 28/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	NT MANOR LLC	27 BRAN	ID AVENUE			
LEASA	NT MANOR LLC	FARIBAL	JLT, MN 5502 ⁻	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 800	Continued From pa	age 5	2 800			
	When interviewed on 9/25/20, at 2:35 p.m. nursing assistant (NA)-D stated R7's often has to wait for assistance to the bathroom which makes her incontinent. This was always upsetting to R7. Most residents wait for an extended period of time to receive an answer to their call light. NA-D has assisted R7 after R7 was incontinent secondary to waiting for a prolonged period of time for the call light to be answered. NA-D stated that there have been, "Too many times," at the beginning of the shift when several residents are soiled and need assistance. NA-D stated the night shift is customarily staffed with two NA's an one licensed practical nurse (LPN) or registered nurse (RN) for the 42 current residents in the facility.					
	LPN-D stated there the individual need	on 9/25/20, at 2:55 p.m. e was insufficient staff to meet s of each resident. The f and residents is low because				
	9/22/20, at 3:51 a.r showed the call ligh the seven day period initiated, 11 (or 21.3 15 minutes to receive	onse time logs dated from n. to 9/28/20, 9:25 a.m. nt was engaged 51 times over od. Of the 51 call light alerts 5%) of these alerts took over ive a response. Seven (or ts took longer than 20 minutes nse.				
	8/20/20, included, s with diagnoses incl injury) and dement assistance with mo (ADL's) and did not	mum Data Set (MDS) dated severe cognitive impairment uding TBI (traumatic brain ia. R1 required extensive ost activities of daily living t ambulate. R1 had 2 or more ce the prior assessment. R1 DS dated 9/16/20.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00568	B. WING			28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 6	2 800			
	AEB [as evidenced admission related to secondary to TBI and disturbances." The "Resident will be sa should incident occ "Provide one on on and wheeling her do The facility provided from 7/21/20 thorou R1 had fallen in the frame. 7/14/20, 7/3 8/11/20, 8/12/20, 8/ 8/16/20, 8/19/20, 8/ 9/14/20 and 9/15/20 Hospital discharge indicated R1 was tr 9/15/20 after sustai	d a running list of R1's falls ugh 9/24/20, which indicated facility 17 times in that time 81/20, 8/1/20, 8/5/20, 8/6/20, 12/20, 8/16/20, 8/16/20, 21/20, 8/29/20, 9/3/20, 21/20, 8/29/20, 9/3/20, 30. summary dated 9/16/20, ansferred to the hospital on ning a fall related to increased y details R1 incurred a				
	R1's progress notes revealed:	s from 9/16/20 to 9/21/20, m. R1 returned to the facility				
	included R1 had att several times after Facility transferred started to yell out a and back. R1 repor neck and back. R1 wheelchair. Facility ratio as the facility	dated 9/16/20, at 5:35 p.m. rempted to crawl out of bed returning from the hospital. R1 to her wheelchair, R1 then nd reported of pain in neck ted to facility of pain in her started to stand up from her initiated a 2 to 1 staff to R1 determined R1 was not safe. contacted and consulted and				

	It of Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00568	B. WING			C 28/2020
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	03/	20/2020
LEASA	NT MANOR LLC		ND AVENUE JLT, MN 5502	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 800	F-	age 7 dian was informed of the	2 800			
	R1's progress note dated, 9/16/20, at 6:24 p.m. included, R1 was transferred back the hospital. A full report was given to the police and transport teams. The floor nurse called the hospital to inform that R1 was returning to them due to safety concerns.					
	included, R1 was r marked behaviors: put herself onto the louder than her use and 1:1, 2:2, 3:3 w remained aggressi 911 to send R1 to o	ed dated 9/16/20, at 6:28 p.m. noted to have continued swore at staff, attempted to e floor, yelling and hollering ual, R1 was extremely agitated ere attempted and R1 ve towards staff. Facility called emergency department (ED) on per physician's orders.				
	stated there were t one attention, but t	on 9/24/20, at 1:00 p.m. NA-B times when R1 required one or they only had one or two staff to residents, so this was not				
		on 9/24/20, at 1:31 p.m. NA-C have enough help to watch R1 e fell a lot.				
	emergency room s would not take R1	on 9/24/20, at 2:56 p.m. the social worker stated the facility back to the facility because enough help to watch her well				
	stated R1 required time to prevent her	on 9/24/20, at 3:22 p.m. NA-D a significant amount of staff from falling and they just did o stay with her all the time.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00568	B. WING			28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE ILT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 8	2 800			
		orked the day shift and often er shift would find R1, "sopping nent brief.				
	stated there was no	on 9/24/20, at 3:45 p.m. LPN-B ot enough staffing to supervise afe as she required individual				
	DON stated due to could not be met at	on 9/28/20, at 10:10 a.m. the limited staffing R1's needs the facility, therefore R1 could fter her last admission to the				
	8/15/20, revealed R impairment. R3 req staff physical assist diagnosis included swallowing concern mouth when eating mouth/cheeks or re	nimum data set (MDS), dated R3 had moderate cognitive uired supervision and one tance for eating. R1's a stroke. R3 had the following ns: loss of liquids/solids from or drinking, holding food in esidual food in mouth after ng during meals or when tions.				
	staff, "The resident with adequate eatin all meals in the dini	updated 9/24/20, directed needs a calm, quiet meal time og time. The resident requires ng room r/t [related to] close eceive meals until supervision				
	stated she worked "understaffed." NA be provided mornin especially if they re assistance with me	on 9/24/20, at 12:56 p.m. NA-A day shift and considered it, -A reported residents waited to g cares prior to breakfast, quired two staff and chanical lift. NA-A stated, R3 assistance for cueing him to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00568	B. WING			28/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 9	2 800			
	get enough fluid. N	or take too big of a bite and to A-A noted R3 often had to wait eat until they had enough staff to help him.				
	stated, R3 required make sure he ate t staff were available	on 9/24/20, at 3:22 p.m. NA-D I staff to closely monitor to he amount he should. Often no to help, he would sit and look vaiting for his plate of food.				
	stated, there were assistance in the d to figure out how to entire time due to d	on 9/24/20, at 3:45 p.m. LPN-E several residents that required ining room and it was difficult o feed R3. R3 required help the choking precautions and e the entire meal time.				
	wheeled self into the wheel chair back a	on 9/25/20, at 12:21 p.m. R3 ne dining room. R3 rolled his nd forth at the table, looking eal was brought to him at 12:41				
	stated there is never room to feed every lucky to have 2 aid R8's admission ME was cognitively inta Parkinson's diseas assistance of 2 sta	on 9/25/20, at 1:21 p.m. NA-F er enough staff in the dining one. "On a good day, we are es to assist all the residents." DS, dated 8/10/20, included, R8 act with a diagnosis of e. R8 required physical ff for transfers and supervision ysical assistance for toileting.				
	staff, "Alteration in	t revised 8/24/20, directed elimination r/t [related to] Assist of 1 with toileting as e."				
	When interviewed	on 9/24/20, at 12:23 p.m.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00568	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/28/2020	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		03/	20/2020
			ID AVENUE	IATE, ZIF CODE		
PLEASA	NT MANOR LLC		JLT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 800	Continued From pa	ge 10	2 800			
	LPN-A stated R8 was independent with cares in the morning and needed more assistance in the afternoon. LPN-A noted R8 might not even turn her call light on but holler out for staff. When interviewed on 9/24/20, at 12:56 p.m. NA-A stated, "We barely touch base," with R8 as she is more independent and staff need to help with					
	When interviewed of stated there was no when she needed if with stiffness and d on her own when he late. R8 stated state on each side of the but it is often over t they do not have er time. R8 stated she the bathroom, she of minutes to get on o	ired more assistance. on 9/28/20, at 10:37 a.m. R8 ot enough staff to help her t. R8 stated she has problems ecreased ability to do things er Parkinson's medication was ff tell her they have a half hour time her medication is due, hat. R8 stated staff tell her hough staff to get it to her on e does not get enough help to often has to wait 20-40 r off the toilet. This causes d she gets even more still and herself even more.				
	dated August 2020, Carbidopa-Levodop Parkinson's disease stiffness, tremors, s control) five times of 4:00 p.m., 7:30 p.m. noted as being adm	ministration record (MAR), , included an order for ba (a medication for treating e symptoms such as muscle spasms, and poor muscle daily; 5:55 a.m., 10:00 a.m., a. and 11:30 p.m. R8 was hinistered the medications at ut the time administered was				
	LPN-D stated R8 w time. LPN-D stated	on 9/28/20, at 10:58 a.m. anted her medications on d R8 reported concerns with ions on time in the evening.				

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:			
		00568	B. WING			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE ILT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 800	Continued From pa	age 11	2 800			
	R8's call light log, dated 9/8/20 through 9/25/20, included, R13 activated her call light 12 times. On two incidents, the response time was between 30 and 40 minutes. On two incidents the response time was between 40 and 50 minutes. On one incident, the response time was over 100 minutes.					
	R13's quarterly MDS dated 9/18/20, included cognitively intact with a diagnosis of multiple sclerosis. R13 required two staff for toileting and was incontinent of bowel and bladder.					
	risk for skin breakd assistance. The ca	ated 7/3/20, incontinence and lown and required staff are plan indicated to keep the nd answer promptly.				
	stated R13 was tota cares. Sometimes breakfast as they d her up before breal up, but is agreeable Often R13 would be	on 9/24/20, at 1:31 p.m. NA-C ally dependent on staff for R13 had to stay in bed for lidn't have enough staff to get kfast. R13 would prefer to get e when they need her to be. e, "saturated" by the time they I to her after breakfast.				
	stated when comin they would find R13 often the only staff competent to use the get R13 up, and du in bed at supper tim	on 9/24/20, at 3:22 p.m. NA-D g on for the afternoon shift 3 soaked in urine. NA-D was on afternoons who was he mechanical lift needed to le to this, often R13 had to stay ne. This would upset R13, but e enough help to always get				
		on 9/28/20, at 11:05 a.m. R13 tinent of urine due to her				

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		BENNI IOMIONIBEN.	A. BUILDING:			
		00568	B. WING			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		DAVENUE LT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 800	Continued From pa	age 12	2 800			
	medical condition, she often has to wait extended periods of time to be changed in order to be dry. In addition, she often is unable to get out of bed because there is not enough staff to help her up. This was upsetting to R13. R13's call light logs for 9/8/20 to 9/25/20, was reviewed. R13's call light response was between 10 and 20 minutes on 30 occurrences, between 20 and 30 minutes on 15 occurrences, between 30 and 40 minutes on seven occurrences, between 40 and 50 minutes on five occurrences and over 60 minutes on four occurrences.					
	R12 had moderate was on hospice ser care. R12's diagnos disease, asthma/ch	S dated 8/14/20, included, cognitive impairment. R12 rvices and required oxygen ses included coronary artery nronic obstructive pulmonary lung disease and respiratory				
	report (MAR/TAR), staff, "Connect 02 bedtime." and "Oxy cannula while at re- marked as complet 9/17/20. The MAR/ has bipap on every cpap placement. Pl every hour overnigh completed on 9/4/2 "Bipap-Nurse must sleeping and at nig	and treatment administration dated August 2020, directed 1.5 L [liters]/min [minute] at rgen at 1.5L/min per nasal st and at night. This was not ted on the night of 9/4/20 and TAR directed "Ensure resident overnight, every night shift for lease ensure Cpap is in place ht." This was not marked as 20 and 9/17/20. and put on use daily when ht." This was not marked as t of 9/4/20 and 9/17/20.				
		p.m. LPN-B stated, R12's and s about staffing. LPN-B R12				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00568	B. WING			28/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	I		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLET DATE
2 800	Continued From pa	ge 13	2 800			
	was, "slower," and "needier," than other residents.					
	R12, (FM)-A stated through video. R12 and oxygen nasal of assist with respirato would notice times not applied, or not a amounts of time, no 3:20 a.m. to 3:50 a. and 10:10 p.m. to 1 reported, during the the facility to alert s the interview, R12 r when she was not of needed, like she was R12 was deterioration physically and was the oxygen. FM-A s she noted no came movement detected 11:34 p.m. and 4:09 required frequent m was on properly. FM she felt like a burde had informed the di concerns and there improvement. R12's call light log, included, R12 active Eleven of those we minutes. Six were a minutes. One was a	 a.m. a family member of she monitored R12's care wore a bipap mask at night annula during the day to bry and breathing issues. FM-A R12's bipap or oxygen was applied properly for significant bring recent example between .m.; 5:00 a.m. to 7:10 a.m., :17 a.m. on 9/24/20. FM-A ese instances, she would call taff, without response. During noted she did not feel well getting the oxygen she as in a "daze". FM-A reported ing both cognitively and more confused when not on stated, on 9/18/20 to 9/19/20 rra activity, indicating no d, in R12's room between D p.m. FM-A noted R12 nonitoring to ensure her bipap M-A reported R12 had told her en to staff. FM-A reported she irector of nursing of her en was no resolution or dated 9/1/20 to 9/29/20, ated the call light 66 times. re answered in 10 to 20 answered between 40 and 50 answered between 40 and 50 answered in over 60 minutes 				
	When interviewed	on 9/24/20, at 12:23 p.m.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURV COMPLETED	
		00568	B. WING		09/2	28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE ILT, MN 55021	1		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	ige 14	2 800			
	for residents. LPN-, sometimes only one center. Residents w they needed with tir hygiene. The workle contributing to staff stated, she had dise and administrator a resolution. LPN-A re nursing assistants w but was busy with c medication pass for there was an overa	were not enough staff to care A explained there were e aide on west side of the care vere not getting the timely care mely toileting, bathing and oad was stressful and burnout and turnover. LPN-A cussed concerns with DON and there had been no eported she helped the with cares when she was able completing treatments and r residents. LPN-A reported Il concern with resident not ssistance with bathing and				
	reported she was p assistant duties to h appointments and v sufficient nursing st peri-cares for reside busy with their own time baths and sho residents were not evening cares when chart a resident refu- had not been offere bathed, when they	on 9/24/20, at 1:31 p.m. NA-C ulled away from her nursing help with electronic medical wound rounds. There was not taff to provide oral care and ents. The nurses were too duties to assist. Most of the wers were missed and assisted with morning and n they preferred. Staff would used a bath, when the resident ed, or chart a resident was were not bathed. This had oth the DON and administrator				
	stated she worked times when she wo building. Resident extended periods o hour. They just cou	on 9/24/20, at 3:22 p.m. NA-D the night shift and there were uld be the only nurse aid in the call lights were on for f time- sometimes over an uld not get to them timely. At ts complain of cold food.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00568	B. WING			28/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
LEASA	NT MANOR LLC		D AVENUE			
		FARIBAL	ILT, MN 5502 ⁻	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 15	2 800			
	been reported to the there was nothing the When interviewed of stated there was on residents. Nurses of personal cares for a addition to their reg were not able to ma were completed. We staffing agency, the they do not have en their work. LPN-B I management and we When interviewed of HSK-A stated nursh "burned out," becau time to meet reside When interviewed of administrator, assiss RN-A were interview facility assessment staffing needs to ma needs. Typically, the assistant per 10 res were residents who wait times, particular "The staff have made noticed "a lot of state administrator noted dynamics and cultu staffing concerns. T was committed to in and chipping in with she felt there was a but felt the communi- reported there was too many staff and	on 9/28/20, at 3:36 p.m. the stant administrator, DON and wed together. There was no to determine the specific eet resident care planned here should be 1 nursing sidents. DON stated there o complained about call light arly at night time. RN-A stated de it seem so drastic" but				

STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		00568	568 B. WING			C 9/28/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
	NT MANOR LLC	27 BRANI	O AVENUE				
FLLAGA		FARIBAU	LT, MN 55021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 800	Continued From pa	ige 16	2 800				
	staff, "Our facility pr staff with the skills a provide care ad ser accordance with re- assessment." and " requirements of dire by the needs of the resident's plan of ca SUGGESTED MET administrator, DON adequate policy and sufficient staffing ba population so reside and timely assistan repositioning, press assistance. The fac these policies and p resident care to ensi- care and services fr facility could report the quality assurant	THOD OF CORRECTION: The l or designee could ensure that d programs are developed for ased on the resident ents received safe, adequate ce with toileting, bathing, sure ulcer care, and eating cility could educate staff on perform routine evaluations of sure residents are receiving or adequate staffing. The the findings of these audits to ce performance improvement for further recommendations to					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			11/2/20	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a					

If continuation sheet 17 of 49

Minnesc	ota Department of He	alth			FORMA	PPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SI COMPLE	
		00568	B. WING	C 09/28	/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
			O AVENUE			
PLEASA	NT MANOR LLC	FARIBAU	LT, MN 550	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
	written order from t	he attending physician that the in in bed or the resident				
	by: Based on observati review, the facility fa assess 3 of 5 resid had fallen, in order prevent further falls for R1 when she su and fractured her si failed to ensure 2 o	ent is not met as evidenced on, interview and document ailed to comprehensively lents (R1, R4, and R3) who to place interventions to . This resulted in actual harm stained 19 falls, broke a finger kull. In addition, the facility f 5 residents (R10 and R5) g risk were served the exture diet.		area acknowledged		
	Findings include:					
	8/20/20, included, s with diagnoses inclu- injury) and dementi assistance with mo- (ADL's) and did not	num Data Set (MDS) dated evere cognitive impairment uding TBI (traumatic brain a. R1 required extensive st activities of daily living ambulate. R4 had 2 or more e the prior assessment. R1 DS dated 9/16/20.				
diamono ta D	included, "Resident having impaired bal medication use. Re following hospitaliza infection] and increa involved in a MVA [I November and suff	A Assessment dated 5/22/20, triggers for falls r/t [related to] lance and daily psychotropic esident has decreased mobility ation for a UTI [urinary tract ased behaviors. Resident was motor vehicle accident] last ered multiple major injuries hited to: skull fractures, TBI,				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED	
		00568	B. WING			C 09/28/2020	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
PLEASA	NT MANOR LLC		D AVENUE JLT, MN 5502 [,]	1			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLE DATE	
2 830	Continued From pa	age 18	2 830				
	increased risk for fa agitation, and daily anticonvulsant, and benzodiazepine me of bowel and bladd history of falls prior any falls since adm to a room closer to Plan to continue to light in reach, and fa recommendations. would be addressed R1's admission Fal 5/19/20, included a falls as identified in there was no analy	edications. She is incontinent er. She does not have a to admission and has not had hission. Resident was moved the nurses station for safety. monitor for safety, keep call follow therapy " The CAA indicated falls d in the care plan. I Review Evaluation dated check list of risk factors for the 5/22/20 CAA. However, sis of fall risk factors or erventions that may mitigate or					
	R1's care plan date AEB [as evidenced admission related t secondary to TBI a disturbances." The "Resident will be sa should incident occ use one assist for t Place bed on low p both sides of bed. unless providing ca chair for comfort. in wheel chair. Pro taking outside and	ed 9/2/20, included, "Fall risk by] multiple falls since to lack of safety awareness and Dementia with behavioral e goal for R1 was listed as, afe and free from serious injury cur." Staff were directed to, transfers with a standing lift. osition. Have fall mats on Leave door open at all times ares. Use a tilt-in-space wheel To be visually supervised when ovide one on one care, such as wheeling her down the hall.					
	identified R1 had fa 7/31/20, 8/1/20, 8/5	ary dated 7/1/20 to 9/28/20, allen 17 times on 7/14/20, 5/20, 8/6/20, 8/11/20, 8/12/20, /16/20, 8/16/20, 8/19/20,					

Minnesota Department of	Health			FORM	IAPPROVE
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION		E SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
					С
	00568	B. WING			28/2020
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	27 BRAN	D AVENUE			
PLEASANT MANOR LLC	FARIBAU	LT, MN 5502	1		
(,	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH		COMPLETE DATE
		IAG	DEFICIENCY)		
2 830 Continued From	22ge 10	2 830			
	U	2 000			
	9/3/20, 9/14/20 and 9/15/20. In				
	gress notes dated 7/29/20 and				
	she had fallen, but these were				
	he Action Summary. There were				
	s or incident reports for the falls				
	Action Summary which were				
	12/20 (2 falls), 8/19/20, or				
	of the falls were identified in the				
	s being a fall from bed onto the				
	ed. These were on 7/31/20,				
	16/20 - three times, 8/21/20- 3				
	30/20, and 9/3/20. 2 falls were wheel chair on 8/29/20 and				
	m recliner on 7/29/20. There				
	tation to determine the				
	the falls that occurred on				
	8/11/20, 8/12/20, 8/19/20 or				
9/14/20.					
	view and Analysis dated 7/20/20,				
	found on the floor on 7/14/20.				
	included, "Staff was walking by				
	nd saw resident lying on the				
	with lack of safety awareness				
	to resident's fall risks due to				
. .	pecified TBI w/o loss of				
	ementia with behavioral				
	e follow-up/intervention section				
	twear, evaluation by PT/OT (occupational therapy), bed in				
	nd soft touch call light. Resident				
	ervised when in wheelchair.				
	ce wheelchair with the ability to				
	hen in chair to provide ore				
	oviding 1:1 (one on one) care				
	er outside and wheeling her				
	Resident with behaviors and often				
	g. Resident requires 1:1				
	and to redirect and provide				
	sident is at high fall risk due to				
innesota Department of Health		μ			1

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00568	B. WING		C 09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETE DATE
2 830	Continued From pa	ge 20	2 830			
	dementia. Residen and restlessness al resident's self trans	eness due to TBI and it also experiences agitation nd could be the reason of ferring to get staff's attention ese interventions were added				
	[certified nursing as [10:00 a.m.] that re- chair. Upon enterir sitting on the footre recliner was tilting f	dated 7/29/20, included, "CNA sistant] told writer at 1000 sident had slid forward in her ng room writer found resident st of her recliner and the forward. Three staff assisted at [sic] of the chair."	λ			
	8:40 PM writer hear room and found res to her bed." Abrasi There was no asse Interventions addeo resident's bedroom and will keep bathro dark." Keeping the	dated 7/31/20, included, "At rd resident calling out from her sident on the floor laying next ons were noted to both knees ssment of this fall. d were, "All staff will make sure door is not closed completely bom light on when room is bathroom light on when the ot added to the care plan.				
	8/5/20, identified R ⁻ 7/31/20. The repor- out of room." No fu- was documented. of notifying the nurs anxiety, agitation, re- change in medication	w and Analysis report dated 1 was found on the floor on t identified R1 wanted to, "get in ther assessment of this fall However, a new interventions se practitioner of, "frequent estlessness and request a ons to decrease anxiety, igitation," was requested.				
	8/5/20, identified R ² on 8/1/20. The forr	w and Analysis report dated 1 had been found on the floor n identified, "Resident wanting This listed the same	1			

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00568	B. WING			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	age 21	2 830			
		8/5/20 report for the fall on s no assessment completed				
	"Resident found on out. Asked her what	dated 8/6/20, included, floor by bed on knees. yelling at she was doing and she said There was no assessment of				
	included, "Writer no medication aide] at was on the floor." I bed. The note india notified due to incre	dated 8/16/20, at 3:46 p.m. otified by TMA [trained 1500 [3:00 p.m.] that resident R1 was sitting on floor mat by cated the physician was then eased anxiety and additional tion was ordered. R1 indicated				
	included, "Aid calle had knees on grou	dated 8/16/20, at 10:28 p.m. d writer into room. Resident nd and torso was still in the confused and wanted to leave	3			
	included, "Aid calle	dated 8/16/20, at 10:35 p.m. d nurse in to find resident arms on the bed. Resident ve facility."				
	included, "Residen bed. Resident had slid out of her bed.	dated 8/16/20, at 10:40 p.m. t was on floor sliding off her just fallen previous to this but Resident was waning [sic] to alling out to staff "someone get				
nnesota D	"Writer observed re	dated 8/21/20, included, esident sitting on floor x 3 on s shift. No injuries noted. Bed				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ!	E SURVEY PLETED
		00568			09/2	28/2020
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST I D AVENUE	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		JLT, MN 5502'	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 22	2 830			
		Asked resident what dent stated, "Trying to get out				
	2:15 PM writer hear Writer found reside her W/C [wheel cha Writer found 1" [inc forehead. Residen footwear, foot peda incontinence noted to writer what happ my head." Cool we	dated 8/29/20, included, "At rd resident yelling from lobby. ent laying on the floor next to air] yelling "Ow my head." ch] x 1.5" abrasion to resident's t was wearing appropriate als in place on W/C, and no . Resident unable to describe ened except that "I fell and hit et towel was applied to und an abrasion on her knee				
	"Writer heard repeat room and found rest bed. Bed was in lo	dated 8/30/20, included, ated yelling out from resident's sident on the floor next to her west position, call light within place both sides of bed, and nent."				
	on right index finge There was no incid	dated 8/30/20, noted a bruise r and a scrape on her head. ent report or assessment to ese injuries occurred.				
		dated 8/31/20, included, the updated on bruise to right				
	R1's progress note sore right finger."	dated 9/2/20, included, "Ice to				
nnoosto D	monitor right index	ord identified staff were to finger related to a fall. identify which fall caused this				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/28/2020	
		00568	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502′	1		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 23	2 830			
	"Writer heard reside when writer arrived floor next to her be- up. Bed was in low place and call light Even though R1 ha there was no comp determine the rease any pattern in time determine why the working to prevent	Id fallen from bed 13 times, rehensive assessment to on R1 was falling from bed, of day or situation, or to current interventions were not further falls.				
		dated 9/10/20, included, t finger related to a fall." "Nail ger appears black."				
	"Monitor right index "Patients finger cor	dated 9//13/20, identified to, t finger related to a fall." ntinues to be black around the s or warmth noted to site. Nail is time."				
	9/15/20, identified F wheelchair on 9/15, cause of R1's fall fr The form identified	ew and Analysis report dated R1 had fallen from her /20. No assessment of the rom the chair was completed. R1 was sent to the or evaluation due to a head				
	dated 9/15/20, inclu floor in bedroom ar herself on floor at n agitated/verbally up upstairs." The res	ssion History and Physical uded, "Patient was found on ad then seemed to throw aursing station. She has been oset at times. Wanting to go ults from a CT of head noted ced fracture of the left				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00568	B. WING		09/28/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830		-	2 830			
	hospital discharge s sustained a closed her right hand 2nd before returning to fracture was in a st had happened in th an injury to R1's rig progress notes on a	one (skull fracture). R1's summary identified R1 had skull fracture and a fracture of finger which would be splinted the nursing home. The finger age of healing, identifying it he past. The facility identified th index finger in the the 8/30/20. However, this was physician or x-rayed until 5/20.				
	stated R1 had faller wheel chair, she wa and required one of fall. NA-B stated th on ones with R1. N interventions that h and trying to stand	on 9/24/20, at 1:00 p.m. NA-B n from bed a lot and from her as constantly trying to stand up n one attention or she would ney did not have time to do one NA-B did not know of any elped R1 with the agitation up all the time, other than to one, winch was not possible required care too.				
	stated R1 had falled scream and throw h interventions she kn the low position and R1 did this she wou remembered R1 ha	on 9/24/20, at 1:31 p.m. NA-C n frequently, she would herself from bed. The only new of was to have the bed in d mats on the floor so when uldn't be injured. NA-C ad a large swollen egg sized ad and had broken her finger, hen this occurred.				
		on 9/24/20, at 3:45 p.m. ourse (LPN)-B stated R1 was				

If continuation sheet 25 of 49

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED C
		00568	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ND AVENUE JLT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	threatening to throw was not enough sta supervision with R1 any assessment of determine why she was R1's behaviors assessment of R1's	ge 25 herself off the bed and v herself off the bed. There iff to do one on ones and . LPN-A was unable to find R1's falls for pattern or to was falling. LPN-A stated it s, but was unable to find any s behaviors to determine why herself," out of bed.	2 830			
	director of nursing (a good system for v are trying to improv should fill out an Ind after each fall. The of these for R1's fal sustained on 7/14/2 9/15/20. The DON assessment had no other falls R1 susta issues and really re which they were un was unable to provi determine if there v what interventions r anxiety/behaviors th frequently. No asse	on 9/28/20, at 10:10 a.m. the (DON) stated they did not have when someone falls and they e this process. The nurse cident Review and Analysis o DON was only able to find 4 lls, which were for the falls 20, 7/31/20, 8/1/20, and did not know why this ot been filled out for any of the ined. R1 had behavioral equired one on one attention, able to provided. The DON ide any assessment to was a pattern to R1's falls, and may assist R1 with her nat led to her falling so essment had been completed o determine interventions that				
	included severe cog diagnosis of demer disturbance. R4 rec mobility and dressin for transfer, toileting	nge MDS dated 8/27/20, gnitive impairment with a ntia with behavioral quired extensive assist for bed ng and total staff assistance g, and personal hygiene. R4 ent of bladder and rejected				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00568	B. WING		C 09/28/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 26	2 830			
		ing the assessment period.				
	r/t having impaired psychotropic medic declined in both mo She has recently er life cares. Has incre of hypoglycemic, ar narcotic, and psych incontinent of bowe recent fall from bed for safety and keep R4's care plan date related to [blank]. S lowest position. Cal Follow PT and OT i function." The most "Ambulate to dining walker] support with 120 ft [feet] x1 [with	led, "Resident triggers for falls balance, history of falls, and ation use. Resident has obility and cognitive functions. nrolled in hospice for end of eased risk of falls r/t daily use ntihypertensive, diuretic, otropic medications. She is and bladder. She has had a l. Plan to continue to monitor call light within reach." d 6/26/20 indicated, "Fall risk Staff were directed, "Bed in I light within reach; fall mat. nstruction for mobility t recent intervention, room with FWW [front wheel n CGA [contact guard assist] a 1 staff] with FWW support". No additional updates had				
	"Assist of 2 w/ [with	ant Care Sheet included,] Hoyer [mechanical lift]; Does nat; call light within reach."				
	included, "At 7:35 p lying on floor next to agitated/anxious an stand/yell at staff. F when trying to posit sling so resident as Ax2 [assist of 2 stat	dated 8/26/20, at 10:51 p.m. or nurse aide found resident b bed. Resident appeared id continued to try and Resident swinging arms at staff ion Hoyer [mechanical lift] sisted back up into bed with ff]. Call light was within reach; e next to bed; bed was in				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00568	B. WING		C 09/28/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE JLT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	lowest position; roo lit." "Resident receiv Seroquel [antipsych agitation/anxiety an following hour. Hos of nursing], and em notified. Writer and about in-facility fam ease resident's anx contact thought it w Emergency contact visit tomorrow." When interviewed of registered nurse (R incident report or po fall. R4's care plan R4, as she is no lor When interviewed of family member (FM allowed to visit relat concerned about R4 would not be able to a visit. No one had possibly visiting to of When interviewed of	m was clear of clutter and well ved PRN [as needed] notic] for increased d was asleep within the pice, ADON [assistant director lergency contact were all emergency contact talked illy visits in hospices [sic] to ciety/agitation and emergency rould be worth a try; t is going to try and stop for a on 9/28/20, at 10:00 a.m. N)-A stated there was no ost fall follow-up report on R4's was incorrect about walking nger able to ambulate. on 9/28/20, at 11:35 a.m. I)-B stated they had not been ted to COVID and was 4's falls. FM-B stated R4 o see them out her window for spoken to them about decrease anxiety. on 9/28/20, at 12:35 p.m.				
	rolling from bed. Tl to the bed and mak reach. LPN-D state	ad fallen a couple times, hey put a mat on the floor next e sure R4 has her call light in ed R4 would not know how to d was unsure why that was an				
	stated, R4 was to h visits after this fall to The DON stated, th	on 9/28/20, at 3:05 p.m. RN-A ave increased family window o aide in preventing more falls ne interdisciplinary team should l, update care sheets and care				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	Сом Сом	E SURVEY PLETED
		00568	B. WING		09/	28/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 5502	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 28	2 830			
	increased family vi communicated to t	icate the change, but the sits had not been he family or added to R4's care /as behind in updating care				
	moderate cognitive including a stroke a extensive staff ass daily living (ADL's), of falls prior to adm	DS dated 8/15/20, included e impairment with diagnoses and dementia. R3 required istance with most activities of was unsteady, had a history hission and had fallen since injury. R3 did not have inations.				
	triggers for falls r/t history of falls, and Resident has had a following hospitaliz weakness. He had increased right side OT at this time with community. Resid r/t daily antihyperte and hypoglycemic of bowel and bladd vision, and hearing of falls prior to adm since admission will something on the f monitor for safety,	ed 8/19/20, included, "Resident having impaired balance, daily antidepressant use. a recent decline in mobility ation for increased overall d a CVA [stroke] and has e weakness. He is in PT and n the goal of returning to the ent is at increased risk of falls onsive, psychotropic, diuretic, medications. He is incontinent ler. He has impaired cognitive, l. Resident does have a history hission and has had one fall here he was reaching for loor. Plan to continue to keep call light in reach, and mmendations. Care planning d.				
	included a checklis before admission, t use that can increa	valuation dated 8/15/20, at of risk factors including fall fall after admission, medication ase falls, cognition and sensory ce, confined to chair, and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00568	B. WING			C 28/2020
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE
			0.000	DEFICIENC	CY)	
2 830	Continued From pa	age 29 nce. There was no analysis of	2 830			
	findings or indication factors would be ac	on on how any of these risk ddressed.				
	related to lack of sa dementia." R3's go and free from falls.	ed 8/12/20, included, "Fall risk afety awareness secondary to bal was, "Resident will be safe " Staff were directed to,				
	for transfers, follow	omptly, use a mechanical lift v therapy instructions, call light otwear, ensue frequently used n.				
	included, "Writer w walked in and saw floor. Resident wa eating supper. Aid resident up using h Resident states tha dropped and he we his wheelchair. Re	dated 8/10/20, at 9:31 p.m. as called into room when aid resident laying prone on the s next to wheelchair and was , ADON and writer helped oyer [mechanical] lift. at he was eating and his spoon ent to go catch it and fell out of esident states he hit his nose as next to the wheel chair."				
	included, "Residen was at the medicin "Pt [patient] was at RN heard some so	dated 8/22/20, at 6:55 p.m. ts door was open and writer e cart adjacent to the room." tempting at self transfers and und that was apparently from d no sooner than he turned, he II to the floor."				
	"Writer was called floor. Resident wa and had his hands Resident was sittin	dated 8/28/20, included, by aid to assist resident off the as on the ground on his bottom holding onto side rail of bed. g crossed legged next to bed tt states he was getting out of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00568	B. WING		09/	28/2020
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
LEASA	NT MANOR LLC		D AVENUE LT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 30	2 830			
		al signs were within normal as reminded to use his call light				
		dated 9/4/20, 10:32 p.m. ansferred and was found bed.				
	"Resident was layir Resident was holdi waiving it in the air right next to him wi Resident states he his room and using out of his way. Res wheelchair while do there were no cats assessment of R3 ¹ room, even though	dated 9/11/20, included, ng on back on the ground. ng handle gripper in hand and Residents wheelchair was th the breaks unlocked. was chasing the cats out of the handle gripper to get them sident then fell out of oing this." "Resident was told in this facility." There was no s belief there were cats in his R3 had not had hallucinations time of the comprehensive				
	LPN-C stated other care plan, no new i any of these falls. any post fall assess The facility had not determine root cau prevent the falls fro increased confusion not assessed other	on 9/28/20, at 10:31 a.m. than what was already in the nterventions were added after LPN-C was unable to provide sment for any of these falls. assessed each fall to se, nor place interventions to om happening again. R3 had n after admission, which was than to offer psych services, actined. Normally, the				
	interdisciplinary tea next day and place	im would assess each fall the new interventions based upon ut this had not been done for				
	When interviewed	on 9/28/20, at 11:44 a.m. the				

O0568 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Z7 BRAND AVENUE FARIBAULT, MN 55021 PLEASANT MANOR LLC Z7 BRAND AVENUE FARIBAULT, MN 55021 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH OBRIGHTOW MORE THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PREFIX (EACH OBRIGHTOW MORE THE PRECEDED BY THE REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CONVENT CONVENT 2 830 DON and RN-A stated the facility was not willing to provide the documentation related to any of the resident's who had fallen as it is part of the facilities, "Risk management." They were unable to provide any documentation that R1, R4, or R3's falls had ever been comprehensively assessed to determine interventions that may prevent further falls from occurring. A facility policy titled, Fall Prevention and Management, revised 2/2020, indicated follow-up procedure for staff after a resident had sustained a fall, "staff will monitor and document the resident's response to and the effectiveness of intervention put in place to prevent further falls for 72 hours post fall. 2. If resident continues to fall, staff will re-evaluate the situation and whether it's appropriate to continue or change the current interventions. As needed, the resident's medical provider will assist reconsider possible causes not previously identified. 5. If it is deterumined and documented that falls may be unavoidable, sta		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
PLEASAUT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 55021 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Recould Corrective Action Should be CROSS-REFERENCED to THE APPROPRIATE DEFICIENCY OMPLET DEFICIENCY 2 830 DON and RN-A stated the facility was not willing to provide the documentation related to any of the resident's who had fallen as it is part of the facilities, "Risk management." They were unable to provide any documentation that R1, R4, or R3's falls had ever been comprehensively assessed to determine interventions that may prevent further falls from occurring. A facility policy titled, Fall Prevention and Management, revised 2/2020, indicated follow-up procedure for staff after a resident had sustained a fall, "staff will monitor and document the resident's response to and the effectiveness of intervention put in place to prevent further falls for 72 hours post fall. 2. If resident continues to fall, staff will re-evaluate the situation and whether it's appropriate to continue or change the current interventions. As needed, the resident's medical provider will assist reconsider possible causes not previously identified. 5. If it is determined and documented that falls may be unavoidable, staff will implement appropriate interventions to			00568	B. WING			
PLEASANT MANOR LLC FARIBAULT, MN 55021 (%) ID PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVA ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (%) OWHET DATE 2 830 Continued From page 31 2 830 2 830 DON and RN-A stated the facility was not willing to provide the documentation related to any of the resident's who had fallen as it is part of the facilities, "Risk management." They were unable to provide any documentation that R1, R4, or R3's falls had ever been comprehensively assessed to determine interventions that may prevent further falls from occurring. A facility policy titled, Fall Prevention and Management, revised 2/2020, indicated follow-up procedure for staff after a resident had sustained a fall, "staff will monitor and document the resident's response to and the effectiveness of interventions, As needed, the resident's medical provider will assist reconsider possible causes not previously identified. 5. If its determined and documented that falls may be unavoidable, staff will implement appropriate interventions to	NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
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		to provide the docu resident's who had facilities, "Risk man to provide any docu R3's falls had ever assessed to determ prevent further falls A facility policy titled Management, revis procedure for staff a fall, "staff will mor resident's response intervention put in p 72 hours post fall. 2 staff will re-evaluate appropriate to conti interventions. As ne provider will assist n not previously ident documented that fa	mentation related to any of the fallen as it is part of the inagement." They were unable imentation that R1, R4, or been comprehensively nine interventions that may from occurring. d, Fall Prevention and ed 2/2020, indicated follow-up after a resident had sustained nitor and document the e to and the effectiveness of place to prevent further falls for 2. If resident continues to fall, e the situation and whether it's nue or change the current eeded, the resident's medical reconsider possible causes ified. 5. If it is determined and Ils may be unavoidable, staff				
		included a diagnosi dysphagia (difficulty throat) and oral pha in the mouth). The risk for aspiration of Recommendations	apy evaluation dated 3/26/20, s of pharyngeal phase / swallowing for issues in the ase dysphagia (due to issues evaluation noted R10 was at f food or fluids. were made for puree bites thorough mastication				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00568	B. WING			C 28/2020
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE
2 830	Continued From pa	age 32	2 830			
	bite/sip, slow pacin between liquids/sol further analysis wo R10 would be appr R10's nutritional sta identified a risk fac	bites before taking another g, single sips, alternate ids. The report indicated uld be required to determine if opriate for diet upgrade. atus CAA dated 4/10/20, tor of a mechanically altered f this risk factor was				
	nutritional alteration meals; had diet res [National Dysphagi ground or are mino pieces, they are mo and could have rec directed to monitor	ted 4/1/20, included, risk for n related to coughing during strictions which included NDD2 a Diet, level 2- meats are to be red no larger than 1/4 inch bist, with some cohesion] diet juested puree. Staff were , document, and report to the ed for signs and symptoms of ns.				
		sing assistant Care Guide al soft diet with pureed meat.				
	identified a mechai meat. Speech thei	iluation dated 4/16/20, nical soft diet with pureed apy recommended to, "have inless resident request pureed				
		Evaluation dated 7/14/20, full upper and lower dentures.				
	was observed to be 12:47 p.m. it was n hamburger patty or hard to eat becaus	on 9/25/20, at 12:42 p.m. R10 e coughing while eating. At oted R10 was eating a regular n a bun. R10 stated it was e she did not have her ad requested the regular patty				

If continuation sheet 33 of 49

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BOILDING.			С
		00568	B. WING		09/	28/2020
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 33	2 830			
	desired one. R10	lled out the burgers and she continued to cough while cked to see if she was alright, ng her dentures.				
	texture and to prov	ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded				
	aide (DA)-A stated mechanical soft die	on 9/25/20, at 1:06 p.m. dietar residents who require a et should have been provided R10 coughing is something while eating.	y			
	(CK)-A stated, a m ground meat, no bi	on 9/25/20, at 1:12 p.m. cook echanical soft diet should have read or hard vegetables. The responsible to ensure the ed.				
	stated R10 does co unaware R10 did n stated if someone	on 9/25/20, at 1:21 p.m. NA-F bugh at meals, she was lot have dentures in. NA-F is coughing like that, they rse to assess if no nurse was				
	stated she normally today got a regular grilling them. R10 dentures, but forgo have to remind her	on 9/25/20, at 1:34 p.m. R10 y gets a ground burger, but whole burger as they were stated she normally wore her at them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H as ok.				
		on 9/25/20, at 3:06 p.m. RN-B ets could be upgraded if they				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		BENTI IO/TION NOMBER.	A. BUILDING:			
		00568	B. WING			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 34	2 830			
	risk versus benefits a risk versus benef	ade, but would have to sign a s statement. R10 did not have its statement signed nor was of choking when provided with er today.				
	Cook-A stated they who had signed a r for a diet upgrade, they can provide it. these. R10 should	on 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the s ordered and not a regular				
	and dated 3/31/20, speech therapy and Mechanical Soft/Gr	tion Form provided by Cook-A had been completed by d indicated R10 was to have a round Meat NDD2 diet atient could downgrade to red.				
	registered dietician coughing during a the DON, food serv therapy. This had facility should not p	on 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to vice director and speech not been done for R10. The provide an upgraded texture eing explained to the resident				
	DON and RN-A sta the correct diet text	on 9/28/20, at 2:37 p.m. the ted it is important to provide ture for residents with ns. A nurse should be notified ghing.				
		6 dated 9/4/20, indicated no nt with diagnoses including,				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00568	B. WING		C 09/28/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	ANT MANOR LLC		D AVENUE ILT, MN 55021	1		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From page	ge 35	2 830			
	coughing and choki swallowing medicat period. The MDS fu oversite, set up whe altered textures. R5's Speech Theray indicated diagnoses and oral phase dysp indicated R5 had m the evaluation had f dentures that did no without dentures, R consistency solids a Advanced. R5 was of materials into the	ne MDS noted R5 had ng during meals or when ions during the assessment rther indicated supervision, en eating and mechanically py Evaluation dated 1/25/19, s of cerebral infarction (stroke) ohagia. The evaluation further issing teeth, and at the time of full upper and partial lower of fit. The evaluation indicated 5 could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx,)				
	dated 1/20/20, indic mechanically altered	ent Area Worksheet (CAA) ated R5 required a d diet. There was no analysis noted to proceed to care				
	risk for nutritional al pain front thorax an diet. Staff were dire	d 3/20/20, indicated R5 was at teration related to chronic d diet restriction for NDD3 cted to monitor, document sian for signs or symptoms of ting.				
		dated, 1/25/19, indicated her NDD3 by Speech therapy.				
		luation dated 9/4/20, identified 03, Dysphagia Advanced diet				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED C
		00568	B. WING		09/	28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 36	2 830			
	and independent in	⁻ staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, d care plan.				
	Dysphagia Advance further directed to p hamburger on bun,	et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw I beans, no bacon, shredded am and milk.				
	R5 sat alone at a ta while she ate her m whole hamburger w covered the burger There were various area including nurs stopped to see why p.m. R5 was obser- for someone get a	ion on 9/25/20, at 12:50 p.m. able and was noted to cough neal. R5's plate contained a with a wedge of lettuce that on a bun and potato chips. a staff throughout the dining ing and dietary, but no one v R5 was coughing. At 12:52 ved to be shaking and asked nurse because she was taff came and brought R5 out				
	stated R5 should habe ans, potato salac should not have ha	on 9/25/20, at 1:06 p.m. DA-A ave received ground meat, d, soft cooked vegetables. R5 d a bun, the burger should and should not have received ole leaf lettuce.				
		on 9/25/20, at 1:10 p.m. R5 asional seizure that are like, o diet restrictions.				
	Cook-A stated the f and pureed texture	on 9/25/20, at 1:12 p.m. facility provided NDD3, NDD2 s. A mechanical diet should no bread or hard vegetables.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00568	B. WING			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 37	2 830			
	mechanical texture ground hamburger, was the cook's resp resident is getting the When interviewed of stated staff should coughing and shou	provided on 9/25/20, a should have included, no bun, potato salad and beans. It consibility to make sure a he appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ld get a nurse. R5 should correct diet and did not know yrong diet.				
	When interviewed of	on 9/25/20, at 1:40 p.m. Inted both dietary and nursing				
	stated a resident is upgraded texture if been signed. The re order from the phys	on 9/25/20, at 3:06 p.m. RN-B ok to be provided an a risk and benefit form had esident should be given the sician if there is no signed risk 5 did not have a signed form.				
	should have receive	p.m. Cook-A- stated R5 ed the ordered diet, but did sponsible for providing the				
	and Benefits policy resident would be in benefits of necessa opportunity regardin care. The resident times and if resider documentation sho	of Care/Interventions, Risk dated 9/11, identified a nformed of the risk and ary care and given the ng their decision in the plan of would be approached 2-3 nt continued to refuse, uld be made on the Refusal of Risk and Benefits and				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	- (X3) DATE SURVE COMPLETED C	
		00568	B. WING			28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 830	Level 1 are allowed foods may be grou no larger than one should be easy to o Moistened ground fish. Moist ground with gravy or sauce pureed bread mixe and slurred breads thickness of produc	age 38 hically Altered. All foods on d. Meats and other select nd or minced into small pieces forth inch. All food items chew. Meats should be or cooked meat, poultry, or or tender meat may be served e. Breads products can be s, moistened bread crumbs that are gelled through entire ct and to avoid all other bread es should be soft, well-cooked				
	inch and should be SUGGESTED ME The director of nur- review/revise polici falls, accidents and proper assessmen implemented and t of a change in con- staff on the policies for evaluating and	ables should be less than 1/2 e easily mashed with a fork. THOD OF CORRECTION: sing or designee, could ies and procedures related to d resident supervision to assure t and interventioins are being he provider is promptly notified dition. They could re-educate s and procedures. A system monitoring consistent these policies could be				
2 905	brought to the facil Committee for revi TIME PERIOD FO (21) days. MN Rule 4658.052 Subp. 4. Positionir	R CORRECTION: Twenty-one 5 Subp. 4 Rehab - Positioning ng. Residents must be	2 905			11/2/20
	positioned in good of residents unable	body alignment. The position to change their own position at least every two hours,				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SL COMPLE	TED
		00568	D. WING		09/28/	2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PLEASA	NT MANOR LLC		DAVENUE LT, MN 550	21		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETI DATE
2 905	Continued From pa	ge 39	2 905			
	been put to bed for has documented th hours during this tin	time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or rdered a different interval.				
	by: Based on observati review, the facility fa timely for 1 of 3 res	ent is not met as evidenced on, interview, and document ailed to provide repositioning idents (R4) reviewed who eloping pressure ulcers.		Area acknowledged		
	Findings include:					
	dated 8/27/20, inclu impairment with a d required extensive total staff assistanc	nge Minimum Data Set (MDS) ided severe cognitive liagnosis of dementia. R4 assist for bed mobility and e for transfer. R4 was at risk levelopment, but did not have ulcer.				
	(CAA) dated 8/28/2 for pressure r/t [rela with bed mobility an incontinence. Resic down r/t cognitive in HTN [hypertension] and daily use of AS. [blood thinner]. She bladder. Resident n over skin tear on LL otherwise intact. Pri place with toileting a	Care Area Assessment 0 included, "Resident triggers ated to] need for assistance of bowel and bladder lent is at risk for skin break npairment, dx [diagnosis] of and Type 2 DM [diabetes] A [aspirin] and Coumadin is incontinent of bowel and toted to have scabbed area LE [lower left extremity]. Skin eventative skin measures in and repositioning q [every] 2				
	wheelchair and mat	listribution cushion to tress to bed, routine skin [morning] and HS [night], and				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00568	B. WING			28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE ILT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From pa	ige 40	2 905			
	weekly skin inspect	tions."				
	alteration in skin int "Monitor skin integr inspection by nurse order. Pressure redistribu chair." Care plan in R4's care plan furth mobility related to e "Dependent with be staff]. Maxi lift (Hoy transfers. Turn and hours]." Additionally "Alteration in comfo 9/8/20: "Position q2 [as needed] with pil R4's nursing assist "Assist of 2 w/ [with	ed 6/26/20 included, "Potential tegrity." Staff were directed to, ity daily. Weekly skin e. Treatment to open areas per distribution mattress to bed. tion cushion to wheelchair, terventions updated 9/1/20. her indicated, "Alteration in end of life" with interventions: ed mobility: A1-2 [assist of 1-2 rer) [mechanical lift] with reposition Q2H [every 2 y R4's care plan specified, ort," with an intervention dated thrs [every 2 hours] and PRN lows for comfort." ant Care Sheet included, 1] Hoyer [mechanical lift]; does a care sheet did not direct staff				
	on how often to ass repositioning. A Hospice Facility V	/isit progress note dated oes verbalize some discomfort				
	starting at 10:25 a. herself in the whee effectively adjust he members asked R4 R4 verbally decline offered to recline R declined. No encou provided. No additio occurred. At 11:46	observation on 9/25/20, m. R4 was attempting to adjust Ichair, but was not able to erself. At 10:34 a.m. 2 staff 4 if she would like to lay down. d. The 2 staff members 4's wheelchair. R4 verbally iragement or re-approach was onal attempts to reposition a.m. licensed practical nurse 4 to her room to check blood				

LEASANT MANOR LLC 27 BRA	A. BUILDING: B. WING ADDRESS, CITY, S' ND AVENUE JULT, MN 5502 ID PREFIX TAG 2 905		
AME OF PROVIDER OR SUPPLIER STREET A LEASANT MANOR LLC 27 BRA FARIBA (X4) ID REFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 905 Continued From page 41 sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining	ADDRESS, CITY, S' ND AVENUE ULT, MN 5502' ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	09/28/2020
LEASANT MANOR LLC 27 BRA FARIBA (X4) ID REFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 905 Continued From page 41 sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining	ND AVENUE ULT, MN 5502 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	E COMPLET
LEASANT MANOR LLC FARIBA (X4) ID REFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 905 Continued From page 41 sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining	ULT, MN 5502 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLET
CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 905 Continued From page 41 sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLET
sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining	2 905		
repositioned. LPN-D brought R4 to the dining			
NA-B assisted R4 into bed and positioned her in bed using 2 pillows. As R4 was laid in bed she stated, "Oh God, that hurts." R4 specified that the pain was in her back.			
When interviewed on 9/25/20, at 2:05 p.m. NA-F and NA-B stated they had assisted R4 with morning cares at 7:30 a.m. NA-F stated they had not had time to assist R4 to lie down or reposition since getting her up at 7:30 a.m. NA-F stated, "There are only two of us on the floor, we try our best, it is terrible." NA-B stated, "It's really terribl we can't get to her, we should be." NA-F and NA-B acknowledged R4 had gone 6.5 hours in the same position in her chair without being repositioned. R4 should be repositioned every 2 hours.	i n e		
When interviewed on 9/28/20, at 3:05 p.m. the director of nursing (DON) stated R4 should be repositioned every 2 hours.			
The facility policy Repositioning (revision date 5/2013) identified, "Repositioning is critical for a resident who is immobile or dependent upon staf for repositioning." The policy further instructs, "Residents who are in a chair should be on an every 1 hour (q1 hour) repositioning schedule. Residents who are in bed should be on at least an every 2 hour (q2 hour) repositioning schedule." Facility policy Skin Assessment and Wound Management (revision date 7/2018) identified "A weekly skin inspection will be completed by licensed staff."	ff		
SUGGESTED METHOD OF CORRECTION:			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00568	B. WING			C 28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PI FASA	ANT MANOR LLC		O AVENUE			
			LT, MN 5502			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 42	2 905			
	all residents at risk they are receiving th treatment/services of from developing and pressure ulcers. Th designee, could cor delivery of care; to e services are implen pressure ulcer devel	ing or designee, could review for pressure ulcers to assure the necessary repositioning to prevent pressure ulcers d to promote healing of the director of nursing or induct random audits of the ensure appropriate care and nented; to reduce the risk for elopment.				
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			11/2/20
	comprehensive resi home must ensure B. a resident who activities of daily livi	is unable to carry out ng receives the necessary n good nutrition, grooming,				
	by: Based on observati review, the facility fa care timely, and fail status after a signifi	ent is not met as evidenced on, interview, and document ailed to provide incontinence ed to reassess continence cant change for 1 of 3 wed for incontinence.		area acknowledged		
	Findings include:					
	6/29/20, included, n with diagnoses inclu	imum Data Set (MDS) dated noderate cognitive impairment uding diabetes, dementia and ed extensive assistance with				

Minnesota Department of Health STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00568	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	Сом	E SURVEY PLETED C 28/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC	27 BRAN	ID AVENUE JLT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	hygiene. R4 was n was occasionally in times during the as R4's incontinence O dated 7/1/20 indica urinary incontinence assistance with tolk incontinence." "She and OT [occupation the goal of returning uses incontinence p dry. Plan to continu and complete peri o HS [night], and with R4's significant cha included severe con dependent upon sta hygiene and was al R4's incontinence O "Resident triggers f toilet use and blado declined in both mo She has recently en life cares. Resident aid in keeping skin current toileting pla [every] AM [morning incontinent episode R4's only Bowel an medical record was	l assistance with personal ot on a toileting program and continent of urine (less than 7 sessment period). Care Area Assessment (CAA) ted, "Resident triggers for e r/t [related to] need for et use and bladder e is in PT [physical therapy] hal therapy] at this time with g to the community. Resident products to aid in keeping skin to the community. Resident products to aid in keeping skin e to with current toileting plan cares q [every] AM [morning], n each incontinent episode." ange MDS dated 8/27/20, gnitive impairment, was totally aff for toileting and personal ways incontinent of urine. CAA dated 8/28/20 included, for urinary incontinence r/t der incontinence. Resident has obility and cognitive function. nrolled in hospice for end of s uses incontinence products to dry. Plan to continue to with n and complete peri cares q g], HS [night], and with each		DEFICIENC		
nnesota D	"Alteration with elim	ed 6/26/20, included, nination." Staff were directed toileting." The care plan had				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00568	B. WING			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 920	Continued From pa	ge 44	2 920			
	8/27/20, MDS noted incontinence to total	ince 6/26/20, even though the d a decline in urinary ally incontinent and an increase s for toileting and personal				
	"Assist of 2 w/ Hoye ambulate." No info	ant Care Sheet included, er [mechanical lift]; does not rmation was included to direct on how to attend to R4's				
	starting at 10:34 a.r if she would like to declined. No encour provided. No addition incontinence cares licensed practical n her room to check insulin. LPN-D then room. Incontinence	observation on 9/25/20, m. 2 staff members asked R4 lay down. R4 verbally tragement or re-approach was onal attempts to provide occurred. At 11:46 a.m. turse (LPN)-D brought R4 to blood sugar and administer to brought R4 to the dining e cares were not provided. At d NA-B assisted R4 into bed visibly wet brief.				
	and NA-B stated th morning cares at 7: not had time to ass since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge	on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or toilet o at 7:30 a.m. NA-F stated, o f us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares.				
	director of nursing should be assisted	on 9/28/20, at 3:05 p.m. the (DON) stated, she thought R4 with incontinent cares every 2 tated she did not know R4's				

	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
00568		B. WING			
				09/2	28/2020
ROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
IT MANOR LLC		-	1		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE	(X5) COMPLET DATE
needs very well. Re was present review and Bladder assess 6/24/20, noting it in bladder. RN-A revie identified R4 had no Bladder assessmen significant decline in June of 2020. RN-/ an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least ew The facility policy To 11/2019) identified, incontinence produc change as needed. Planning" (revision care plan is to be m condition and care in changes."	egistered nurse (RN)-A who ved R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and ot had an updated Bowel and nt, even though she had a n condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4 shecked for incontinence and very 2 hours. bileting Assistance (policy date "If a client wears an ct, check if soiled or wet and " The facility policy Care date 6/2019) identified "The nodified and updated as the needs of the resident				
The director of nurse review and revise p responsible staff to dependant on faciliti comprehensively as designee could con resident cares to er	sing and/or designee could rocedures and educate provide care to residents' ty staff, based on residents' ssessed needs. The DON or iduct audits of dependent nsure their personal care				
TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa needs very well. Re was present review and Bladder assess 6/24/20, noting it in bladder. RN-A revi identified R4 had no Bladder assessmer significant decline in June of 2020. RN-, an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least ew The facility policy To 11/2019) identified, incontinence produ change as needed. Planning" (revision care plan is to be m condition and care changes." SUGGESTED MET The director of nurs review and revise p responsible staff to dependant on facilit comprehensively as designee could com resident cares to er needs are met time TIME PERIOD FOF	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 45 needs very well. Registered nurse (RN)-A who was present reviewed R4's most recent Bowel and Bladder assessment, which was dated 6/24/20, noting it indicated R4 was continent of bladder. RN-A reviewed R4's medical record and identified R4 had not had an updated Bowel and Bladder assessment, even though she had a significant decline in condition since admission in June of 2020. RN-A stated R4 should have had an updated assessment with the significant change MDS completed in August 2020. RN-A explained they were behind on assessments and R4 was on their work list, "to be caught up." R4 should have been checked for incontinence and change at least every 2 hours. The facility policy Toileting Assistance (policy date 11/2019) identified, "If a client wears an incontinence product, check if soiled or wet and change as needed." The facility policy Care Planning" (revision date 6/2019) identified "The care plan is to be modified and updated as the condition and care needs of the resident changes." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise procedures and educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal care needs are met timely and consistently. TIME PERIOD FOR CORRECTION: Twenty-one	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 45 2 920 needs very well. Registered nurse (RN)-A who was present reviewed R4's most recent Bowel and Bladder assessment, which was dated 6/24/20, noting it indicated R4 was continent of bladder. RN-A reviewed R4's medical record and identified R4 had not had an updated Bowel and Bladder assessment, even though she had a significant decline in condition since admission in June of 2020. RN-A stated R4 should have had an updated assessment with the significant change MDS completed in August 2020. RN-A explained they were behind on assessments and R4 was on their work list, "to be caught up." R4 should have been checked for incontinence and changed at least every 2 hours. The facility policy Toileting Assistance (policy date 11/2019) identified, "If a client wears an incontinence product, check if soiled or wet and change as needed." The facility policy Care Planning" (revision date 6/2019) identified "The care plan is to be modified and updated as the condition and care needs of the resident changes." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise procedures and educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal care needs are met timely and consistently. TIME PERIOD FOR CORRECTION: Twenty-one	FARIBAUL1, WN 55021 PROVIDER'S PLANLOF O (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG PREFIX (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TH DEFICIENCY Continued From page 45 2 920 Continued From page 45 2 920 Continued From page 45' A generative state of the page	Image: Construction of the second construction of th

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OATE SURVEY
		00568	B. WING		C 09/28/2020
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	09/20/2020
	NT MANOR LLC	27 BRAN	ID AVENUE		
		FARIBAL	JLT, MN 550	21	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
21810	Continued From pa	ige 46	21810		
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810		11/2/20
	residents shall have medical and person needs. Appropriate care designed to en highest level of phy This right is limited	riate health care. Patients and e the right to appropriate nal care based on individual e care for residents means nable residents to achieve their vsical and mental functioning. where the service is not iblic or private resources.			
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview, and document ailed to provide care in a ted dignity for 1 of 1 resident lignity concerns.		area acknowledged	
	Findings include:				
	7/28/20, included m with a diagnosis of incontinent and req	nimum Date Set (MDS) dated noderate cognitive impairment a stroke. R7 was occasionally juired assistance by one staff on and off of the toilet.			
	Rehab Care Asses dated 9/25/20, inclu decline in mobility,	s of daily living)/Functional sment Area Worksheet (CAA) uded, R7 has had a recent was occasionally incontinent er, and needed assistance for est.			
	required assistance dependent assist, c	ed 7/29/20, included, R7 e for, "Bathing with max to dressing with max assist, et-up with minimal assist,			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		`́сом	E SURVEY PLETED C
		00568	B. WING		09/	28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21810	Continued From page	ge 47	21810			
	occasionally inconti with toilet use."	nent, and requires assistance				
	was lying in bed. R7 facility is very bad. I there seems to be r facility. Call lights ca hour. I push the call bathroom and no or wet myself. I feel hi chair and embarras cleaned up and cha brow was furled and R7 stated this happ When interviewed of nursing assistant (N wait for assistance to her incontinent. This Most residents wait time to receive an a has assisted R7 after secondary to waiting time for the call ligh that there have bee beginning of the shi soiled and need ass night shift is custom one licensed praction nurse (RN) for the 4 facility. When interviewed of LPN-D state there is individual needs of	on 9/25/20, at 2:00 p.m. R7 7 stated, "Staffing for the blame the State because no staffing guidelines for this an go unanswered for over an light when I need to go to the ne comes until it is too late. I umiliated about wetting in the sed about needing to be nged." R7 looked angry, her d her face became slightly red. ens at least once a week. on 9/25/20, at 2:35 p.m. IA)-D stated R7's often has to to the bathroom which makes s was always upsetting to R7. for an extended period of nswer to their call light. NA-D er R7 was incontinent g for a prolonged period of t to be answered. NA-D stated n, "too many times," at the ft when several residents are sistance. NA-D stated the harily staffed with two NA's and cal nurse (LPN) or registered b 2 current residents in the on 9/25/20, at 2:55 p.m. s insufficient staff to meet the each resident. The morale sidents is low because of this.				

If continuation sheet 48 of 49

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00568	B. WING	B. WING		C 28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21810	R7's call light responent 9/22/20, at 3:51 a.m showed the call ligh the seven day period initiated, 11 (or 21.5 15 minutes to receinent 14%) of these alerts to receive a responent During a phone call p.m. the administration staffing or facility as determining staffing administrator stated include one staff me "More comradery a was needed among would improve care they are working or SUGGESTED MET The administrator, of designee could revi- ensure residents re timely fashion. It co residents that may concern. The facility	onse time logs dated from n. to 9/28/20, 9:25 a.m. nt was engaged 51 times over od. Of the 51 call light alerts 5%) of these alerts took over ve a response. Seven (or s took longer than 20 minutes se. I interview on 9/28/20, at 3:30 tor stated they do not have a ssessment in place to assist in g needs at this time. The d current staffing rations ember for every ten residents. nd better communication," g the staff. These measures e. The administrator stated than this initiative. THOD OF CORRECTION: director of nursing (DON), or iew and revise procedures to acieve the care they need in a ould also address other be at risk for the same y could educate staff on these	t			
	needs of resident(s audits for an amour quality assessment improvement (QAP compliance. The ac	I) committee could ensure Iministrator, DON, or designee t information back to QAPI to	9			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		00568	B. WING	B. WING		C 09/28/2020	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
LEASA	NT MANOR LLC		D AVENUE LT, MN 5502 ²	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
2 000	Initial Comments		2 000				
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall	Minnesota Statute, section action order has been issued ey. If, upon reinspection, it is siency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.					
	corrected requires requirements of the number and MN Re When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with all e rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was					
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.					
	survey was conduct with State Licensur NOT in compliance Please indicate in y correction that you	TS: 0 and 9/28/20, an abbreviated sted to determine compliance re. Your facility was found to be with the MN State Licensure. your electronic plan of have reviewed these orders, re when they will be completed.					

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

TITLE

(X6) DATE

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	`́сом	E SURVEY PLETED C
		00568	B. WING		09/28/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE ILT, MN 5502 [,]	1		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)		COMPLET
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED H5090056C: MN Ru H5090057C MN Ru Rule 4658.0525 Su H5090059C MN Ru	laints were found to be with a licensing order issued: ule 4658.0520 Subp. 1 Ile 4658.0510 Subp. 1 and MN bp. 6 B Ile 4658.0510 Subp. 1; MN bp. 6 B.; and MN Rule				
	unsubstantiated: H	laints were found to be 5090055C and H5090058C ed in ePOC and therefore a uired at the bottom of the first				
2 800	MN Rule 4658.0510 Staffing requiremen) Subp. 1 Nursing Personnel; its	2 800			
	home must have or number of qualified registered nurses, li nursing assistants t residents at all nurs in all buildings if mo	requirements. A nursing a duty at all times a sufficient nursing personnel, including icensed practical nurses, and o meet the needs of the ses' stations, on all floors, and ore than one building is ides relief duty, weekends, sements.				
	by: Based on observati review, the facility fa staffing to provide fo planned needs for 8 R1, R3, R8, R13 an	ent is not met as evidenced on, interview and document ailed to ensure sufficient or the individualized care 3 of 8 residents (R5, R7, R4, id R12), 12 of 15 staff (LPN-B, -D, NA-C, NA-J, NA-B, NA-F,				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00568	B. WING		09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 2	2 800			
	members (FM)-A,	A and NA-C) and 1 of 3 family reviewed for sufficient staffing. ial to affect all 42 current				
	Findings include:					
	included cognitively stroke with paralysi the body and a seiz	num Data Set dated 9/4/20, r intact with diagnoses of s or weakness on one side of cure disorder. R5 required from staff for toileting and				
	1/20/20, included,	nt Worksheet (CAA) dated R5 extensive assistance with ing (ADL) including bathing				
	needed assistance shower/bath with or	ated 8/12/20, included, R5 with toilet use and ne assist twice a week on esday evenings with skin				
	licensed practical n not getting the time toileting, bathing an	on 9/24/20, at 12:23 p.m. urse (LPN)-A stated, R5 was ly care she needed with id hygiene as there was not id complain about this.				
	stated, "This facility over an hour to get R5 stated it takes a the bathroom, and, Sunday and a show would rather I just to	on 9/24/20, at 2: 20 p.m. R5 is very short staffed. I wait an answer to my call light." long time to get help to go to "I should have a bath every ver every Wednesday. The aid ake a shower because it takes . Sometime, I get neither				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X1) PROVIDER/SUPPLIER/CLIA	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		00568	B. WING			C 28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ρι έδρα	NT MANOR LLC	27 BRAN	D AVENUE			
		FARIBAL	JLT, MN 5502 ²	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 3	2 800			
	This was upsetting	to R5.				
	nursing assistant (N assistance with bat she had to wait for have enough staff t	on 9/24/20, at 3:22 p.m. a NA)-D stated R5 required hing and toileting, but often assistance as they do not o get to everyone timely. ve to skip R5's bath as they n time.				
	When interviewed on 9/24/20, at 3:45 p.m. a licensed practical nurse (LPN)-B stated, R5 complained of not getting her shower on a regular basis. This was upsetting to her, but they were doing the best they could.					
	not receive a bath of stated, "R5's showe evening due to time did not get done du bath requires two a only two on the floo had a lot to do and time to get in the ba	ncern Report included, R5 did or shower on 7/22/20. NA-I er did not get done on Sunday e." NA-J stated, "R5's shower e to running out of time. Her ids which [NA-I] and I were the r until 6 p.m. After 6 we still ended up not having enough ath R5 wanted. There was also t was supposed to get done one."				
	2020: R5 received again until 8/17/20,	Is dated July to September a shower on 7/19 but not and then not again until ed a bath on 9/13/20, but not				
	p.m.) to 9/29/20 (2: the call light 166 tim	l light log from 9/1/20 (6:53 24 p.m.), indicated, R5 used nes. Of the 166 instances, the 20 minutes on 69 occasions of	r			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C	
		00568	B. WING			/28/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
PLEASA	NT MANOR LLC		D AVENUE	1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From page 4 R7's admission MDS dated 7/28/20, included moderate cognitive impairment with a diagnosis of a stroke. R7 was occasionally incontinent and required assistance by one staff person to transfer on and off of the toilet.		2 800				
	R7's ADL (activities of daily living)/Functional Rehab Care Assessment Area Worksheet (CAA) dated 9/25/20, included, R7 has had a recent decline in mobility, was occasionally incontinent of bowel and bladder, and needed assistance for toileting upon request.						
	required assistance dependent assist, d personal hygiene se	d 7/29/20, included, R7 e for, "Bathing with max to Iressing with max assist, et-up with minimal assist, nent, and requires assistance					
	nursing assistant (N week she found R7 when she started he	on 9/24/20, at 1:31 p.m. a IA)-C reported the previous soiled halfway up her back er shift. NA-C reported there iff to meet R7's toileting and timely manner.					
	was lying in bed. R facility is very bad. I there seems to be r facility. Call lights ca hour. I push the cal bathroom and no or wet myself. I feel h chair and embarras cleaned up and cha brow was furled and	on 9/25/20, at 2:00 p.m. R7 7 stated, "Staffing for the I blame the State because no staffing guidelines for this an go unanswered for over an I light when I need to go to the ne comes until it is too late. I umiliated about wetting in the seed about needing to be anged." R7 looked angry, her d her face became slightly red. ens at least once a week.					

	Dta Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00568	B. WING		09/28/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 800	When interviewed of nursing assistant (N wait for assistance her incontinent. Thi Most residents wait time to receive an a has assisted R7 aft secondary to waitin time for the call ligh that there have bee beginning of the shi soiled and need ass night shift is custom one licensed praction nurse (RN) for the 4 facility. When interviewed of LPN-D stated there the individual needs morale among staff of this. R7's call light respon 9/22/20, at 3:51 a.m showed the call ligh the seven day period initiated, 11 (or 21.5 15 minutes to recein 14%) of these alerts to receive a respon R1's quarterly Minin 8/20/20, included, s with diagnoses inclu- injury) and dementi- assistance with mos (ADL's) and did not	on 9/25/20, at 2:35 p.m. NA)-D stated R7's often has to to the bathroom which makes s was always upsetting to R7. for an extended period of answer to their call light. NA-D er R7 was incontinent g for a prolonged period of it to be answered. NA-D stated in, "Too many times," at the iff when several residents are sistance. NA-D stated the harily staffed with two NA's and cal nurse (LPN) or registered 42 current residents in the on 9/25/20, at 2:55 p.m. was insufficient staff to meet s of each resident. The and residents is low because onse time logs dated from in. to 9/28/20, 9:25 a.m. it was engaged 51 times over od. Of the 51 call light alerts 5%) of these alerts took over ve a response. Seven (or s took longer than 20 minutes		DEFICIENCY		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00568			СОМ	E SURVEY PLETED C 28/2020	
					00,	03/20/2020	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
PLEASA	NT MANOR LLC		ND AVENUE ULT, MN 5502′	1			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 800	Continued From pa	ge 6	2 800				
	AEB [as evidenced admission related to secondary to TBI and disturbances." The "Resident will be sa should incident occ "Provide one on on- and wheeling her do The facility provided from 7/21/20 thorou R1 had fallen in the frame. 7/14/20, 7/3 8/11/20, 8/12/20, 8/ 8/16/20, 8/19/20, 8/ 9/14/20 and 9/15/20 Hospital discharge indicated R1 was tr 9/15/20 after sustai agitation. Summary	d a running list of R1's falls ugh 9/24/20, which indicated facility 17 times in that time 81/20, 8/1/20, 8/5/20, 8/6/20, 12/20, 8/16/20, 8/16/20, 21/20, 8/29/20, 9/3/20, 0. summary dated 9/16/20, ansferred to the hospital on ning a fall related to increased details R1 incurred a					
	revealed:	tinger. s from 9/16/20 to 9/21/20, m. R1 returned to the facility					
	included R1 had att several times after Facility transferred started to yell out at and back. R1 repor neck and back. R1 wheelchair. Facility ratio as the facility of	dated 9/16/20, at 5:35 p.m. tempted to crawl out of bed returning from the hospital. R1 to her wheelchair, R1 then nd reported of pain in neck ted to facility of pain in her started to stand up from her initiated a 2 to 1 staff to R1 determined R1 was not safe. contacted and consulted and					

STATEMEN	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
PI FASA	NT MANOR LLC		D AVENUE			
			JLT, MN 5502 [,]			
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2 800	Continued From pa	ge 7	2 800			
	hospital. R1's guard transfer situation.	lian was informed of the				
	included, R1 was tr full report was given teams. The floor nu	dated, 9/16/20, at 6:24 p.m. ansferred back the hospital. A n to the police and transport irse called the hospital to returning to them due to				
	included, R1 was no marked behaviors: put herself onto the louder than her usu and 1:1, 2:2, 3:3 we remained aggressiv 911 to send R1 to e	d dated 9/16/20, at 6:28 p.m. oted to have continued swore at staff, attempted to floor, yelling and hollering ual, R1 was extremely agitated ere attempted and R1 /e towards staff. Facility called emergency department (ED) on per physician's orders.				
	stated there were ti one attention, but th	on 9/24/20, at 1:00 p.m. NA-B mes when R1 required one on ney only had one or two staff to esidents, so this was not				
		on 9/24/20, at 1:31 p.m. NA-C have enough help to watch R1 e fell a lot.				
	emergency room so would not take R1 b	on 9/24/20, at 2:56 p.m. the ocial worker stated the facility back to the facility because nough help to watch her well				
	stated R1 required time to prevent her	on 9/24/20, at 3:22 p.m. NA-D a significant amount of staff from falling and they just did o stay with her all the time.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00568	B. WING		09/28/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 8	2 800			
	NA-D stated she worked the day shift and often when arriving for her shift would find R1, "sopping wet," in her incontinent brief.					
	stated there was no	on 9/24/20, at 3:45 p.m. LPN-B ot enough staffing to supervise afe as she required individual				
	DON stated due to could not be met at	on 9/28/20, at 10:10 a.m. the limited staffing R1's needs the facility, therefore R1 could after her last admission to the				
	8/15/20, revealed R impairment. R3 req staff physical assist diagnosis included swallowing concern mouth when eating mouth/cheeks or re	nimum data set (MDS), dated R3 had moderate cognitive uired supervision and one tance for eating. R1's a stroke. R3 had the following ns: loss of liquids/solids from or drinking, holding food in esidual food in mouth after ng during meals or when tions.				
	staff, "The resident with adequate eatin all meals in the dini	updated 9/24/20, directed needs a calm, quiet meal time og time. The resident requires ng room r/t [related to] close eceive meals until supervision				
	stated she worked "understaffed." NA be provided mornin especially if they re assistance with me	on 9/24/20, at 12:56 p.m. NA-A day shift and considered it, -A reported residents waited to g cares prior to breakfast, quired two staff and chanical lift. NA-A stated, R3 assistance for cueing him to				

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		00568	B. WING		C 09/28/2020	
JAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STA			
			ID AVENUE			
PLEASA	NT MANOR LLC	FARIBAU	JLT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 9	2 800			
	get enough fluid. N	or take too big of a bite and to A-A noted R3 often had to wait eat until they had enough staff o help him.				
	stated, R3 required make sure he ate th staff were available	on 9/24/20, at 3:22 p.m. NA-D staff to closely monitor to ne amount he should. Often no to help, he would sit and look vaiting for his plate of food.				
	stated, there were s assistance in the di to figure out how to entire time due to c	on 9/24/20, at 3:45 p.m. LPN-E several residents that required ning room and it was difficult feed R3. R3 required help the hoking precautions and a the entire meal time.				
	wheeled self into th wheel chair back ar	on 9/25/20, at 12:21 p.m. R3 e dining room. R3 rolled his nd forth at the table, looking al was brought to him at 12:41				
	stated there is never room to feed every lucky to have 2 aide R8's admission MD was cognitively inta Parkinson's disease assistance of 2 staf	on 9/25/20, at 1:21 p.m. NA-F er enough staff in the dining one. "On a good day, we are es to assist all the residents." IS, dated 8/10/20, included, R8 ct with a diagnosis of e. R8 required physical f for transfers and supervision ysical assistance for toileting.				
	staff, "Alteration in e	revised 8/24/20, directed elimination r/t [related to] Assist of 1 with toileting as ."				
	When interviewed of	on 9/24/20, at 12:23 p.m.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00568	B. WING		09/28/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 ²	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 10	2 800			
	LPN-A stated R8 was independent with cares in the morning and needed more assistance in the afternoon. LPN-A noted R8 might not even turn her call light on but holler out for staff. When interviewed on 9/24/20, at 12:56 p.m. NA-A stated, "We barely touch base," with R8 as she is more independent and staff need to help with residents who required more assistance.					
	stated there was no when she needed i with stiffness and d on her own when h late. R8 stated stat on each side of the but it is often over t they do not have er time. R8 stated sh the bathroom, she minutes to get on o	on 9/28/20, at 10:37 a.m. R8 of enough staff to help her t. R8 stated she has problems lecreased ability to do things er Parkinson's medication was ff tell her they have a half hour time her medication is due, that. R8 stated staff tell her hough staff to get it to her on e does not get enough help to often has to wait 20-40 or off the toilet. This causes d she gets even more still and herself even more.	3			
	dated August 2020 Carbidopa-Levodop Parkinson's diseas stiffness, tremors, s control) five times of 4:00 p.m., 7:30 p.m noted as being adm	ministration record (MAR), , included an order for ba (a medication for treating e symptoms such as muscle spasms, and poor muscle daily; 5:55 a.m., 10:00 a.m., n. and 11:30 p.m. R8 was ninistered the medications at out the time administered was				
	LPN-D stated R8 w time. LPN-D stated	on 9/28/20, at 10:58 a.m. vanted her medications on d R8 reported concerns with tions on time in the evening.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00568	B. WING		09/28/2020	
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PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	1		
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2 800	Continued From pa	age 11	2 800			
	R8's call light log, dated 9/8/20 through 9/25/20, included, R13 activated her call light 12 times. On two incidents, the response time was between 30 and 40 minutes. On two incidents the response time was between 40 and 50 minutes. On one incident, the response time was over 100 minutes.					
	cognitively intact w sclerosis. R13 req	OS dated 9/18/20, included ith a diagnosis of multiple uired two staff for toileting and bowel and bladder.				
	risk for skin breakc assistance. The ca	ated 7/3/20, incontinence and lown and required staff are plan indicated to keep the nd answer promptly.				
	stated R13 was tot cares. Sometimes breakfast as they of her up before brea up, but is agreeable Often R13 would b	on 9/24/20, at 1:31 p.m. NA-C ally dependent on staff for R13 had to stay in bed for lidn't have enough staff to get kfast. R13 would prefer to get e when they need her to be. e, "saturated" by the time they d to her after breakfast.				
	stated when comin they would find R13 often the only staff competent to use t get R13 up, and du in bed at supper tin	on 9/24/20, at 3:22 p.m. NA-D g on for the afternoon shift 3 soaked in urine. NA-D was on afternoons who was he mechanical lift needed to ue to this, often R13 had to stay ne. This would upset R13, but e enough help to always get				
noosta D		on 9/28/20, at 11:05 a.m. R13 tinent of urine due to her				

If continuation sheet 12 of 49

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00568	B. WING		09/	28/2020
IAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, ST D AVENUE	ATE, ZIP CODE		
PLEASA	NT MANOR LLC		LT, MN 55021	l		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 12	2 800			
	periods of time to b In addition, she ofte because there is no This was upsetting R13's call light logs reviewed. R13's ca 10 and 20 minutes 20 and 30 minutes 30 and 40 minutes between 40 and 50 between 50 and 60	she often has to wait extended the changed in order to be dry. En is unable to get out of bed but enough staff to help her up. to R13. If or 9/8/20 to 9/25/20, was Il light response was between on 30 occurrences, between on 15 occurrences, between on seven occurrences, minutes on five occurrences, minutes on 5 occurrences as on four occurrences.				
	R12 had moderate was on hospice ser care. R12's diagnos disease, asthma/ch	S dated 8/14/20, included, cognitive impairment. R12 vices and required oxygen ses included coronary artery pronic obstructive pulmonary lung disease and respiratory				
	report (MAR/TAR), staff, "Connect 02 bedtime." and "Oxy cannula while at res marked as complet 9/17/20. The MAR/ has bipap on every cpap placement. Pl every hour overnigh completed on 9/4/2 "Bipap-Nurse must sleeping and at nig	nd treatment administration dated August 2020, directed 1.5 L [liters]/min [minute] at gen at 1.5L/min per nasal st and at night. This was not red on the night of 9/4/20 and TAR directed "Ensure resident overnight, every night shift for ease ensure Cpap is in place nt." This was not marked as 0 and 9/17/20. and put on use daily when ht." This was not marked as t of 9/4/20 and 9/17/20.				
		p.m. LPN-B stated, R12's and s about staffing. LPN-B R12				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		COM	E SURVEY PLETED	
		00568	B. WING			C 09/28/2020	
IAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
PLEASAN	MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800 C	Continued From pa	ge 13	2 800				
	vas, "slower," and ' esidents.	"needier," than other					
F ti a a v n a 3 a m ti t v n F p ti s n 1 n v s h c i i F ii E n n	R12, (FM)-A stated hrough video. R12 and oxygen nasal of issist with respirato yould notice times not applied, or not a imounts of time, not 220 a.m. to 3:50 a. and 10:10 p.m. to 1 eported, during the he facility to alert s he interview, R12 r when she was not g reeded, like she was R12 was deterioration hysically and was he oxygen. FM-A s he noted no came novement detected 1:34 p.m. and 4:05 equired frequent m vas on properly. FM he felt like a burde had informed the di concerns and there mprovement. R12's call light log, ncluded, R12 active Eleven of those we ninutes. Six were a ninutes. Six were a ninutes. One was a	9 a.m. a family member of she monitored R12's care wore a bipap mask at night cannula during the day to ory and breathing issues. FM-A R12's bipap or oxygen was applied properly for significant oting recent example between .m.; 5:00 a.m. to 7:10 a.m., :17 a.m. on 9/24/20. FM-A ese instances, she would call taff, without response. During noted she did not feel well getting the oxygen she as in a "daze". FM-A reported ing both cognitively and more confused when not on stated, on 9/18/20 to 9/19/20 rra activity, indicating no d, in R12's room between 9 p.m. FM-A noted R12 nonitoring to ensure her bipap M-A reported R12 had told her en to staff. FM-A reported she irector of nursing of her e was no resolution or dated 9/1/20 to 9/29/20, ated the call light 66 times. re answered in 10 to 20 answered between 30 to 40 answered between 40 and 50					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМ	E SURVEY PLETED C
		00568	B. WING		09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 5502	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	LPN-A stated there for residents. LPN- sometimes only on center. Residents of they needed with ti hygiene. The work contributing to staff stated, she had dis and administrator a resolution. LPN-A r nursing assistants but was busy with of medication pass for there was an overa getting the timely a hygiene. When interviewed reported she was p assistant duties to appointments and sufficient nursing s peri-cares for resid	age 14 e were not enough staff to care A explained there were he aide on west side of the care were not getting the timely care mely toileting, bathing and load was stressful and f burnout and turnover. LPN-A scussed concerns with DON and there had been no reported she helped the with cares when she was able completing treatments and or residents. LPN-A reported all concern with resident not assistance with bathing and on 9/24/20, at 1:31 p.m. NA-C pulled away from her nursing help with electronic medical wound rounds. There was not taff to provide oral care and lents. The nurses were too in duties to assist. Most of the	2 800	DEFICIENCY		
	residents were not evening cares whe chart a resident ref had not been offer bathed, when they	owers were missed and assisted with morning and in they preferred. Staff would fused a bath, when the resident ed, or chart a resident was were not bathed. This had oth the DON and administrator				
	stated she worked times when she wo building. Resident extended periods o hour. They just co	on 9/24/20, at 3:22 p.m. NA-D the night shift and there were ould be the only nurse aid in the call lights were on for of time- sometimes over an uld not get to them timely. At hts complain of cold food.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00568				CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/28/2020	
	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S		-	
PLEASA	NT MANOR LLC		JLT, MN 5502 [,]	1		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLET DATE
2 800	Continued From pa	ge 15	2 800			
	been reported to the there was nothing to When interviewed of stated there was or residents. Nurses of personal cares for standing addition to their reg were not able to may were completed. We staffing agency, the they do not have er their work. LPN-B management and we When interviewed of HSK-A stated nursi "burned out," becau- time to meet reside When interviewed of administrator, assiss RN-A were interviewed facility assessment staffing needs to m needs. Typically, the assistant per 10 resident were residents who wait times, particula "The staff have may noticed "a lot of standing administrator noted dynamics and cultur staffing concerns. The was committed to in	on 9/28/20, at 3:36 p.m. the stant administrator, DON and wed together. There was no to determine the specific eet resident care planned here should be 1 nursing sidents. DON stated there o complained about call light arly at night time. RN-A stated de it seem so drastic" but				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00568	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/28/2020	
				03/	20/2020	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 55021	I		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLET DATE
2 800	Continued From pa	ge 16	2 800			
	staff, "Our facility pristaff with the skills a provide care ad ser accordance with re- assessment." and " requirements of dire by the needs of the resident's plan of ca SUGGESTED MET administrator, DON adequate policy and sufficient staffing ba population so reside and timely assistan repositioning, press assistance. The fac these policies and p resident care to ensi- care and services fi facility could report the quality assurant	HOD OF CORRECTION: The or designee could ensure that d programs are developed for ased on the resident ents received safe, adequate ce with toileting, bathing, sure ulcer care, and eating sility could educate staff on perform routine evaluations of sure residents are receiving or adequate staffing. The the findings of these audits to ce performance improvement or further recommendations to				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a				

	ota Department of He					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			`́СОМ	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE ILT, MN 5502 [,]	1		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETE DATE
2 830	Continued From pa	ge 17	2 830			
		he attending physician that the in in bed or the resident i bed.				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 3 of 5 residents (R1, R4, and R3) who had fallen, in order to place interventions to prevent further falls. This resulted in actual harm for R1 when she sustained 19 falls, broke a finger and fractured her skull. In addition, the facility failed to ensure 2 of 5 residents (R10 and R5) reviewed for choking risk were served the ordered modified texture diet.					
	Findings include:					
	8/20/20, included, s with diagnoses inclu- injury) and dementi assistance with mo- (ADL's) and did not	num Data Set (MDS) dated severe cognitive impairment uding TBI (traumatic brain a. R1 required extensive st activities of daily living ambulate. R4 had 2 or more e the prior assessment. R1 DS dated 9/16/20.				
	included, "Resident having impaired ba medication use. Re following hospitaliza infection] and increa involved in a MVA [I November and suff	a Assessment dated 5/22/20, triggers for falls r/t [related to] lance and daily psychotropic esident has decreased mobility ation for a UTI [urinary tract ased behaviors. Resident was motor vehicle accident] last ered multiple major injuries nited to: skull fractures, TBI,	,			

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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1			
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2 830	Continued From pa	age 18	2 830				
	increased risk for fa agitation, and daily anticonvulsant, and benzodiazepine me of bowel and bladd history of falls prior any falls since adm to a room closer to Plan to continue to light in reach, and f recommendations. would be addresse R1's admission Fall 5/19/20, included a falls as identified in there was no analy	edications. She is incontinent er. She does not have a to admission and has not had hission. Resident was moved the nurses station for safety. monitor for safety, keep call follow therapy " The CAA indicated falls d in the care plan. Il Review Evaluation dated to check list of risk factors for the 5/22/20 CAA. However, sis of fall risk factors or erventions that may mitigate or					
	AEB [as evidenced admission related to secondary to TBI a disturbances." The "Resident will be sa should incident occ use one assist for to Place bed on low p both sides of bed. unless providing ca chair for comfort. in wheel chair. Pro-	ed 9/2/20, included, "Fall risk by] multiple falls since to lack of safety awareness and Dementia with behavioral e goal for R1 was listed as, afe and free from serious injury cur." Staff were directed to, transfers with a standing lift. position. Have fall mats on Leave door open at all times ares. Use a tilt-in-space wheel To be visually supervised when povide one on one care, such as wheeling her down the hall.					
	R1's Action Summa identified R1 had fa 7/31/20, 8/1/20, 8/5	ary dated 7/1/20 to 9/28/20, allen 17 times on 7/14/20, 5/20, 8/6/20, 8/11/20, 8/12/20, /16/20, 8/16/20, 8/19/20,					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00568	B. WING		C 09/28/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	ANT MANOR LLC	27 BRANI FARIBAUI	O AVENUE _T, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	 8/21/20, 8/29/20, 9/ addition, R1's progr 8/30/20 identified sl not included on the no progress notes of identified on the Act dated 8/11/20, 8/12, 9/14/20. Twelve of progress notes as to mat next to the bed 8/5/20, 8/6/20, 8/16 times, 8/29/20, 8/30 identified from a wh 9/15/20. 1 fall from was no documentat circumstances of th 7/14/20, 8/11/12, 8/ 9/14/20. R1's Incident Revie included, R1 was for Incident Analysis im resident's room and floor." "Resident wi which contributes to diagnosis of unspect consciousness; Det disturbance." The f listed: proper footw (physical therapy/or lowest position and to be visually super Provide tilt-in-space recline resident whe comfort. Staff prov such as taking her of down the hall. "Rest times heard yelling." 	ge 19 3/20, 9/14/20 and 9/15/20. In ress notes dated 7/29/20 and he had fallen, but these were Action Summary. There were or incident reports for the falls tion Summary which were /20 (2 falls), 8/19/20, or the falls were identified in the being a fall from bed onto the . These were on 7/31/20, /20 - three times, 8/21/20- 3 0/20, and 9/3/20. 2 falls were heel chair on 8/29/20 and recliner on 7/29/20. There tion to determine the he falls that occurred on 11/20, 8/12/20, 8/19/20 or w and Analysis dated 7/20/20, bund on the floor on 7/14/20. cluded, "Staff was walking by a saw resident lying on the th lack of safety awareness to resident's fall risks due to cified TBI w/o loss of mentia with behavioral follow-up/intervention section we are evaluation by PT/OT ccupational therapy), bed in soft touch call light. Resident vised when in wheelchair. wheelchair with the ability to en in chair to provide ore iding 1:1 (one on one) care putside and wheeling her sident with behaviors and often Resident requires 1:1 d to redirect and provide	2 830	DEFICIENC	т)	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00568	B. WING			28/2020
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PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 20	2 830			
	dementia. Resider and restlessness a resident's self trans	eness due to TBI and at also experiences agitation nd could be the reason of aferring to get staff's attention ese interventions were added				
	R1's progress note dated 7/29/20, included, "CNA [certified nursing assistant] told writer at 1000 [10:00 a.m.] that resident had slid forward in her chair. Upon entering room writer found resident sitting on the footrest of her recliner and the recliner was tilting forward. Three staff assisted resident back to seat [sic] of the chair."					
	8:40 PM writer hear room and found rest to her bed." Abrasi There was no asse Interventions added resident's bedroom and will keep bathro dark." Keeping the	dated 7/31/20, included, "At rd resident calling out from her sident on the floor laying next ions were noted to both knees. ssment of this fall. d were, "All staff will make sure door is not closed completely oom light on when room is bathroom light on when the ot added to the care plan.				
	8/5/20, identified R 7/31/20. The report out of room." No fut was documented. of notifying the nurst anxiety, agitation, re- change in medication	ew and Analysis report dated 1 was found on the floor on t identified R1 wanted to, "get urther assessment of this fall However, a new interventions se practitioner of, "frequent estlessness and request a ons to decrease anxiety, agitation," was requested.				
	8/5/20, identified R on 8/1/20. The form	ew and Analysis report dated 1 had been found on the floor n identified, "Resident wanting ' This listed the same				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
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IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	4		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 21	2 830			
		8/5/20 report for the fall on s no assessment completed				
	"Resident found on out. Asked her what	dated 8/6/20, included, floor by bed on knees. yelling at she was doing and she said There was no assessment of				
	included, "Writer no medication aide] at was on the floor." bed. The note indi notified due to incre	dated 8/16/20, at 3:46 p.m. otified by TMA [trained : 1500 [3:00 p.m.] that resident R1 was sitting on floor mat by cated the physician was then eased anxiety and additional tion was ordered. R1 indicated				
	included, "Aid calle had knees on grou	dated 8/16/20, at 10:28 p.m. d writer into room. Resident nd and torso was still in the confused and wanted to leave	•			
	included, "Aid calle	dated 8/16/20, at 10:35 p.m. d nurse in to find resident arms on the bed. Resident ve facility."				
	included, "Residen bed. Resident had slid out of her bed.	dated 8/16/20, at 10:40 p.m. t was on floor sliding off her just fallen previous to this but Resident was waning [sic] to alling out to staff "someone get				
	"Writer observed re	dated 8/21/20, included, esident sitting on floor x 3 on s shift. No injuries noted. Bed				

	ota Department of He	(X1) provider/supplier/clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED
		00568	B. WING			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ρι έδρα	NT MANOR LLC	27 BRAN	D AVENUE			
	-		JLT, MN 5502 [,]			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 22	2 830			
		Asked resident what dent stated, "Trying to get out				
	2:15 PM writer hear Writer found reside her W/C [wheel cha Writer found 1" [inc forehead. Residen footwear, foot peda incontinence noted to writer what happ my head." Cool we	dated 8/29/20, included, "At rd resident yelling from lobby. nt laying on the floor next to air] yelling "Ow my head." h] x 1.5" abrasion to resident's t was wearing appropriate ls in place on W/C, and no . Resident unable to describe ened except that "I fell and hit to towel was applied to and an abrasion on her knee				
	"Writer heard repeat room and found rest bed. Bed was in lo	dated 8/30/20, included, ated yelling out from resident's sident on the floor next to her west position, call light within place both sides of bed, and nent."				
	on right index finge There was no incide	dated 8/30/20, noted a bruise r and a scrape on her head. ent report or assessment to ese injuries occurred.				
		dated 8/31/20, included, the updated on bruise to right				
	R1's progress note sore right finger."	dated 9/2/20, included, "Ice to				
	monitor right index	ord identified staff were to finger related to a fall. identify which fall caused this				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
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2 830	Continued From pa	ge 23	2 830				
	"Writer heard reside when writer arrived floor next to her bee up. Bed was in low place and call light Even though R1 ha there was no comp determine the rease any pattern in time determine why the working to prevent R1's progress note "Monitor right index bed and part of fing R1's progress note	d fallen from bed 13 times, rehensive assessment to on R1 was falling from bed, of day or situation, or to current interventions were not further falls. dated 9/10/20, included, finger related to a fall." "Nail yer appears black."					
	"Patients finger con	finger related to a fall." Itinues to be black around the or warmth noted to site. Nail is time."					
	9/15/20, identified F wheelchair on 9/15, cause of R1's fall fr The form identified	w and Analysis report dated R1 had fallen from her /20. No assessment of the om the chair was completed. R1 was sent to the or evaluation due to a head					
	dated 9/15/20, inclu floor in bedroom an herself on floor at n agitated/verbally up upstairs." The rest	ssion History and Physical aded, "Patient was found on ad then seemed to throw sursing station. She has been uset at times. Wanting to go ults from a CT of head noted ced fracture of the left					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COMI	E SURVEY PLETED
		00568	B. WING			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 830	posterial parietal bo hospital discharge s sustained a closed her right hand 2nd before returning to fracture was in a st had happened in th an injury to R1's rig progress notes on a not assessed by a p hospitalized on 9/19 When interviewed of stated R1 had faller wheel chair, she wa and required one o fall. NA-B stated th on ones with R1. N interventions that h and trying to stand sit with her one on as other residents r When interviewed of stated R1 had faller scream and throw h interventions she k the low position and R1 did this she wou remembered R1 ha area on her forehea but did not know wh When interviewed of guardian stated the sustaining a fractur undiagnosed for so	one (skull fracture). R1's summary identified R1 had skull fracture and a fracture of finger which would be splinted the nursing home. The finger age of healing, identifying it is past. The facility identified ht index finger in the the 8/30/20. However, this was physician or x-rayed until 5/20. on 9/24/20, at 1:00 p.m. NA-B n from bed a lot and from her as constantly trying to stand up n one attention or she would hey did not have time to do one IA-B did not know of any elped R1 with the agitation up all the time, other than to one, winch was not possible required care too. on 9/24/20, at 1:31 p.m. NA-C n frequently, she would herself from bed. The only new of was to have the bed in d mats on the floor so when uldn't be injured. NA-C ad a large swollen egg sized ad and had broken her finger, hen this occurred. on 9/24/20, at 3:07 p.m. R1's by were concerned about R1 ed finger that went		DEFICIENCY)		
nnesota D		urse (LPN)-B stated R1 was				

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00568	B. WING			C 28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PI FASA	NT MANOR LLC		ID AVENUE			
			JLT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 25	2 830			
	threatening to throw was not enough sta supervision with R1 any assessment of determine why she was R1's behaviors assessment of R1's	herself off the bed and v herself off the bed. There iff to do one on ones and . LPN-A was unable to find R1's falls for pattern or to was falling. LPN-A stated it by but was unable to find any behaviors to determine why herself," out of bed.				
	director of nursing (a good system for w are trying to improv should fill out an Ind after each fall. The of these for R1's fal sustained on 7/14/2 9/15/20. The DON assessment had no other falls R1 susta issues and really re which they were un was unable to provi determine if there w what interventions r anxiety/behaviors th frequently. No asse	on 9/28/20, at 10:10 a.m. the (DON) stated they did not have when someone falls and they e this process. The nurse cident Review and Analysis DON was only able to find 4 ls, which were for the falls 20, 7/31/20, 8/1/20, and did not know why this of been filled out for any of the ined. R1 had behavioral quired one on one attention, able to provided. The DON de any assessment to vas a pattern to R1's falls, and may assist R1 with her nat led to her falling so essment had been completed o determine interventions that				
	included severe coo diagnosis of demen disturbance. R4 rec mobility and dressir	nge MDS dated 8/27/20, gnitive impairment with a utia with behavioral quired extensive assist for bed ng and total staff assistance g, and personal hygiene. R4				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00568		CONSTRUCTION	COM	E SURVEY PLETED C 28/2020
					097	20/2020
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S ⁻ D AVENUE	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		LT, MN 5502 [°]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 26	2 830			
		ing the assessment period.				
	r/t having impaired psychotropic medic declined in both mc She has recently er life cares. Has incre of hypoglycemic, ar narcotic, and psych incontinent of bowe recent fall from bed for safety and keep R4's care plan date related to [blank]. S lowest position. Cal Follow PT and OT i function." The most "Ambulate to dining walker] support with 120 ft [feet] x1 [with	led, "Resident triggers for falls balance, history of falls, and ation use. Resident has obility and cognitive functions. nrolled in hospice for end of eased risk of falls r/t daily use httihypertensive, diuretic, otropic medications. She is I and bladder. She has had a . Plan to continue to monitor call light within reach." d 6/26/20 indicated, "Fall risk Staff were directed, "Bed in I light within reach; fall mat. nstruction for mobility recent intervention, room with FWW [front wheel n CGA [contact guard assist] I staff] with FWW support". No additional updates had				
	"Assist of 2 w/ [with	ant Care Sheet included,] Hoyer [mechanical lift]; Does at; call light within reach."				
	included, "At 7:35 p lying on floor next to agitated/anxious an stand/yell at staff. F when trying to posit sling so resident as Ax2 [assist of 2 stat	dated 8/26/20, at 10:51 p.m. m nurse aide found resident b bed. Resident appeared id continued to try and Resident swinging arms at staff ion Hoyer [mechanical lift] sisted back up into bed with ff]. Call light was within reach; e next to bed; bed was in				

	NT OF DEFICIENCIES	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00568	B. WING			C 28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 830	lowest position; roo lit." "Resident receiv Seroquel [antipsych agitation/anxiety an following hour. Hos of nursing], and em notified. Writer and about in-facility fam ease resident's anx contact thought it w Emergency contact visit tomorrow." When interviewed of registered nurse (R incident report or po fall. R4's care plan R4, as she is no lor When interviewed of family member (FM allowed to visit relat concerned about R4 would not be able to a visit. No one had possibly visiting to o When interviewed of LPN-D stated R4 ha rolling from bed. Th to the bed and mak reach. LPN-D state use the call light an intervention. When interviewed of stated, R4 was to h visits after this fall to	m was clear of clutter and wel ved PRN [as needed] notic] for increased d was asleep within the pice, ADON [assistant director ergency contact were all emergency contact talked ily visits in hospices [sic] to iety/agitation and emergency rould be worth a try; is going to try and stop for a on 9/28/20, at 10:00 a.m. N)-A stated there was no ost fall follow-up report on R4's was incorrect about walking nger able to ambulate. on 9/28/20, at 11:35 a.m. I)-B stated they had not been ted to COVID and was 4's falls. FM-B stated R4 o see them out her window for spoken to them about		DEFICIENCY)	

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00568	B. WING			C 28/2020
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	age 28	2 830			
	increased family vis communicated to the	cate the change, but the sits had not been he family or added to R4's care ras behind in updating care				
	moderate cognitive including a stroke a extensive staff assi daily living (ADL's), of falls prior to adm	OS dated 8/15/20, included impairment with diagnoses and dementia. R3 required istance with most activities of was unsteady, had a history hission and had fallen since njury. R3 did not have inations.				
	triggers for falls r/t history of falls, and Resident has had a following hospitalizative weakness. He had increased right side OT at this time with community. Reside r/t daily antihyperte and hypoglycemic r of bowel and bladd vision, and hearing of falls prior to adm since admission wh something on the fil monitor for safety,	ed 8/19/20, included, "Resident having impaired balance, daily antidepressant use. a recent decline in mobility ation for increased overall a CVA [stroke] and has e weakness. He is in PT and a the goal of returning to the ent is at increased risk of falls nsive, psychotropic, diuretic, medications. He is incontinent er. He has impaired cognitive, . Resident does have a history bission and has had one fall here he was reaching for loor. Plan to continue to keep call light in reach, and mmendations. Care planning d.				
	included a checklis before admission, f use that can increa	valuation dated 8/15/20, t of risk factors including fall fall after admission, medication se falls, cognition and sensory ce, confined to chair, and				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	Сом	E SURVEY PLETED
		00568	B. WING		09/28/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502	1		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 29	2 830			
		nce. There was no analysis of n on how any of these risk ldressed.				
	related to lack of sa dementia." R3's go and free from falls.' Answer call light pro for transfers, follow	d 8/12/20, included, "Fall risk ifety awareness secondary to bal was, "Resident will be safe ' Staff were directed to, comptly, use a mechanical lift therapy instructions, call light otwear, ensue frequently used h.				
	included, "Writer wa walked in and saw floor. Resident was eating supper. Aid, resident up using he Resident states tha dropped and he we his wheelchair. Res	dated 8/10/20, at 9:31 p.m. as called into room when aid resident laying prone on the s next to wheelchair and was ADON and writer helped oyer [mechanical] lift. t he was eating and his spoon nt to go catch it and fell out of sident states he hit his nose as next to the wheel chair."				
	included, "Resident was at the medicine "Pt [patient] was att RN heard some some	dated 8/22/20, at 6:55 p.m. s door was open and writer e cart adjacent to the room." empting at self transfers and und that was apparently from no sooner than he turned, he I to the floor."				
	"Writer was called h floor. Resident wa and had his hands Resident was sitting sitting up. Residen his wheel chair to g	dated 8/28/20, included, by aid to assist resident off the s on the ground on his bottom holding onto side rail of bed. g crossed legged next to bed t states he was getting out of et into bed. Resident then and onto his bottom next to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00568	B. WING			C 28/2020
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		27 BRAN	ID AVENUE			
LEASA	NT MANOR LLC	FARIBAL	JLT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 30	2 830			
		al signs were within normal as reminded to use his call ligh	t			
		dated 9/4/20, 10:32 p.m. ansferred and was found bed.				
	"Resident was layir Resident was holdi waiving it in the air. right next to him wi Resident states he his room and using out of his way. Res wheelchair while do there were no cats assessment of R3's room, even though	dated 9/11/20, included, ng on back on the ground. ng handle gripper in hand and Residents wheelchair was th the breaks unlocked. was chasing the cats out of the handle gripper to get them sident then fell out of bing this." "Resident was told in this facility." There was no s belief there were cats in his R3 had not had hallucinations time of the comprehensive				
	LPN-C stated other care plan, no new i any of these falls. any post fall assess The facility had not determine root cau prevent the falls fro increased confusio not assessed other which the family de interdisciplinary tea	on 9/28/20, at 10:31 a.m. r than what was already in the nterventions were added after LPN-C was unable to provide sment for any of these falls. assessed each fall to se, nor place interventions to om happening again. R3 had n after admission, which was than to offer psych services, eclined. Normally, the am would assess each fall the new interventions based upon				
		ut this had not been done for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 00568 B. WING C 09/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE C 09/28/2020 PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 55021 V (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	Minnesc	ota Department of He	ealth			FORM	APPROVED
00568 B. WING 09/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 55021 0 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) (X5) (EACH DEFICIENCY) 2 830 Continued From page 31 2 830 Continued From page 31 2 830 DON and RN-A stated the facility was not willing to provide the documentation related to any of the resident's who had fallen as it is part of the facilities, "Risk management." They were unable to provide any documentation that R1, R4, or R3's falls had ever been comprehensively assessed to determine interventions that may prevent further falls from occurring. A facility policy titled, Fall Prevention and Management, revised 2/2020, indicated follow-up procedure for staff after a resident had sustained a fall, "staff will monitor and document the resident's response to and the effectiveness of intervention put in place to prevent further falls for 72 hours post fall. 2. If resident continues to fall, staff will re-evaluate the situation and whether it's appropriate to continue or change the current interventions. As needed, the resident's medical provider will assist reconsider possible causes not previously identified. 5. If it is determim	STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
21 SUMMARY STATEMENT OF DEFICIENCIES FARIBAULT, MN 55021 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG DPOVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (%5) (000000000000000000000000000000000000			00568	B. WING			
PLEASANT MANOR LLC FARIBAULT, MN 55021 (%) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDTS EP PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) (%) COMMENT TAG 2 830 Continued From page 31 2 830 EACH CORRECTIVE ACTION SHOLD BE resident's who had failen as it is part of the facilities, "Risk management." They were unable to provide the documentation related to any of the resident's who had failen as it is part of the facilities, "Risk management." They were unable to provide any documentation that R1, R4, or R3's fails had ever been comprehensively assessed to determine interventions that may prevent further fails from occurring. A facility policy titled, Fail Prevention and Management, revised 2/2020, indicated follow-up procedure for staff after a resident had sustained a fail, "staff will monitor and document the resident's response to and the effectiveness of intervention put in place to prevent further fails for 72 hours post fail. 2. If resident continues to fail, staff will re-evaluate the situation and whether it's appropriate to continue or change the current interventions. As needed, the resident's medical provider will assist reconsider possible causes not previously identified. 5. If it is determined and documented that fails may be unavoidable, staff	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
(X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET TAG 2 830 Continued From page 31 2 830 DON and RN-A stated the facility was not willing to provide the documentation related to any of the resident's who had fallen as it is part of the facilities, "Risk management." They were unable to provide any documentation that R1, R4, or R3's falls had ever been comprehensively assessed to determine interventions that may prevent further falls from occurring. A facility policy titled, Fall Prevention and Management, revised 2/2020, indicated follow-up procedure for staff after a resident had sustained a fall, "staff will monitor and document the resident's response to and the effectiveness of intervention put in place to prevent further falls for 72 hours post fall. 2. If resident continues to fall, staff will re-evaluate the situation and whether it's appropriate to continue or change the current interventions. As needed, the resident's medical provider will assist reconsider possible causes not previously identified. 5. If it is determined and documented that falls may be unavoidable, staff			27 BRAN	D AVENUE			
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) complete DATE 2 830 Continued From page 31 2 830 DON and RN-A stated the facility was not willing to provide the documentation related to any of the resident's who had fallen as it is part of the facilities, "Risk management." They were unable to provide any documentation that R1, R4, or R3's falls had ever been comprehensively assessed to determine interventions that may prevent further falls from occurring. A facility policy titled, Fall Prevention and Management, revised 2/2020, indicated follow-up procedure for staff after a resident had sustained a fall, "staff will monitor and document the resident's response to and the effectiveness of intervention put in place to prevent further falls for 72 hours post fall. 2. If resident continues to fall, staff will re-evaluate the situation and whether it's appropriate to continue or change the current interventions. As needed, the resident's medical provider will assist reconsider possible causes not previously identified. 5. If it is determined and documented that falls may be unavoidable, staff	PLEASA		FARIBAU	LT, MN 5502 ⁻	1		
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prevent serious injury from falls. 6. Care plans will be updated to reflect fall interventions."		to provide the docu resident's who had facilities, "Risk man to provide any docu R3's falls had ever assessed to determ prevent further falls A facility policy titled Management, revis procedure for staff a fall, "staff will mor resident's response intervention put in p 72 hours post fall. 2 staff will re-evaluate appropriate to conti interventions. As ne provider will assist in not previously ident documented that fa will implement appr prevent serious inju	mentation related to any of the fallen as it is part of the magement." They were unable umentation that R1, R4, or been comprehensively nine interventions that may from occurring. d, Fall Prevention and ed 2/2020, indicated follow-up after a resident had sustained nitor and document the to and the effectiveness of place to prevent further falls for 2. If resident continues to fall, the situation and whether it's inue or change the current eeded, the resident's medical reconsider possible causes tified. 5. If it is determined and ulls may be unavoidable, staff opriate interventions to ury from falls. 6. Care plans will				
R10's quarterly MDS dated 7/14/20, included cognitively intact with diagnoses of diabetes and lung disease. R10 required supervision and set up assistance with eating.		cognitively intact wi lung disease. R10	th diagnoses of diabetes and required supervision and set				
R10's Speech Therapy evaluation dated 3/26/20, included a diagnosis of pharyngeal phase dysphagia (difficulty swallowing for issues in the throat) and oral phase dysphagia (due to issues in the mouth). The evaluation noted R10 was at risk for aspiration of food or fluids. Recommendations were made for puree		included a diagnosi dysphagia (difficulty throat) and oral pha in the mouth). The risk for aspiration o	is of pharyngeal phase y swallowing for issues in the ase dysphagia (due to issues evaluation noted R10 was at f food or fluids.				
consistency, small bites thorough mastication			bites thorough mastication				

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00568	B. WING			C 28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ΡΙ ΕΔSΔ	NT MANOR LLC	27 BRAN	ID AVENUE			
		FARIBAL	JLT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 32	2 830			
	bite/sip, slow pacing between liquids/soli further analysis wou	bites before taking another g, single sips, alternate ds. The report indicated uld be required to determine if opriate for diet upgrade.				
	R10's nutritional status CAA dated 4/10/20, identified a risk factor of a mechanically altered diet. No analysis of this risk factor was completed.					
	nutritional alteration meals; had diet res [National Dysphagia ground or are mino- pieces, they are mo and could have req directed to monitor,	ed 4/1/20, included, risk for related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be ed no larger than 1/4 inch sist, with some cohesion] diet uested puree. Staff were document, and report to the d for signs and symptoms of is.				
		ing assistant Care Guide al soft diet with pureed meat.				
	identified a mechar meat. Speech ther	luation dated 4/16/20, ical soft diet with pureed apy recommended to, "have nless resident request pureed				
		Evaluation dated 7/14/20, ull upper and lower dentures.				
	was observed to be 12:47 p.m. it was no hamburger patty on	on 9/25/20, at 12:42 p.m. R10 coughing while eating. At oted R10 was eating a regular a bun. R10 stated it was e she did not have her				

STATEMEN	ota Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	COMI	E SURVEY PLETED
		00568			09/2	28/2020
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 33	2 830			
	desired one. R10	lled out the burgers and she continued to cough while cked to see if she was alright, ng her dentures.				
	texture and to prov	ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded				
	aide (DA)-A stated mechanical soft die	on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating.	/			
	(CK)-A stated, a m ground meat, no bi	on 9/25/20, at 1:12 p.m. cook echanical soft diet should have read or hard vegetables. The responsible to ensure the ed.				
	stated R10 does co unaware R10 did n stated if someone	on 9/25/20, at 1:21 p.m. NA-F bugh at meals, she was not have dentures in. NA-F is coughing like that, they rse to assess if no nurse was				
	stated she normally today got a regular grilling them. R10 dentures, but forgo have to remind her	on 9/25/20, at 1:34 p.m. R10 y gets a ground burger, but whole burger as they were stated she normally wore her of them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H as ok.				
		on 9/25/20, at 3:06 p.m. RN-B ets could be upgraded if they				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
		00568	B. WING		09/:	28/2020
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 34	2 830			
	risk versus benefits a risk versus benef	ade, but would have to sign a s statement. R10 did not have fits statement signed nor was of choking when provided with er today.				
	Cook-A stated they who had signed a r for a diet upgrade, they can provide it. these. R10 should	on 9/25/20, at 3:08 p.m. have a file of each resident risk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the s ordered and not a regular				
	and dated 3/31/20, speech therapy and Mechanical Soft/Gi	tion Form provided by Cook-A had been completed by d indicated R10 was to have a round Meat NDD2 diet atient could downgrade to red.				
	registered dietician coughing during a the DON, food serv therapy. This had facility should not p	on 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to vice director and speech not been done for R10. The provide an upgraded texture eing explained to the resident				
	DON and RN-A sta the correct diet tex	on 9/28/20, at 2:37 p.m. the ated it is important to provide ture for residents with ns. A nurse should be notified ghing.				
		S dated 9/4/20, indicated no ent with diagnoses including,				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C	
		00568	B. WING	/ING		09/28/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
PLEASA	NT MANOR LLC		D AVENUE	1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 35	2 830				
	coughing and choki swallowing medicat period. The MDS fu	ne MDS noted R5 had ng during meals or when ions during the assessment rther indicated supervision, en eating and mechanically					
	R5's Speech Therapy Evaluation dated 1/25/19, indicated diagnoses of cerebral infarction (stroke) and oral phase dysphagia. The evaluation further indicated R5 had missing teeth, and at the time of the evaluation had full upper and partial lower dentures that did not fit. The evaluation indicated without dentures, R5 could not chew regular consistency solids and recommended Dysphagia Advanced. R5 was at risk of aspiration (passage of materials into the vocal cords), laryngeal penetration (passage of materials into the larynx,) and/or asphyxiation.						
	dated 1/20/20, indic mechanically altere	ent Area Worksheet (CAA) ated R5 required a d diet. There was no analysis noted to proceed to care					
	risk for nutritional a pain front thorax an diet. Staff were dire	d 3/20/20, indicated R5 was at Iteration related to chronic d diet restriction for NDD3 cted to monitor, document sian for signs or symptoms of ting.					
		dated, 1/25/19, indicated her NDD3 by Speech therapy.					
		lluation dated 9/4/20, identified 03, Dysphagia Advanced diet					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00568	B. WING		C 09/28/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE	(X5) COMPLET DATE
IAG			IAG	DEFICIENCY)		
2 830	Continued From pa	ge 36	2 830			
	and independent in	staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, care plan.				
	Dysphagia Advance further directed to p hamburger on bun,	et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw I beans, no bacon, shredded am and milk.				
	R5 sat alone at a ta while she ate her m whole hamburger w covered the burger There were various area including nurs stopped to see why p.m. R5 was obser- for someone get a	ion on 9/25/20, at 12:50 p.m. able and was noted to cough heal. R5's plate contained a vith a wedge of lettuce that on a bun and potato chips. staff throughout the dining ing and dietary, but no one v R5 was coughing. At 12:52 ved to be shaking and asked nurse because she was taff came and brought R5 out				
	stated R5 should habe beans, potato salac should not have ha	on 9/25/20, at 1:06 p.m. DA-A ave received ground meat, d, soft cooked vegetables. R5 d a bun, the burger should and should not have received ole leaf lettuce.				
		on 9/25/20, at 1:10 p.m. R5 asional seizure that are like, o diet restrictions.				
	Cook-A stated the f and pureed texture	on 9/25/20, at 1:12 p.m. facility provided NDD3, NDD2 s. A mechanical diet should no bread or hard vegetables.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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		00568	B. WING		09/	28/2020
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 37	2 830			
	mechanical texture ground hamburger, was the cook's resp resident is getting t	provided on 9/25/20, a should have included, no bun, potato salad and beans. It consibility to make sure a he appropriate texture. on 9/25/20, at 1:21 p.m. NA-F				
	stated staff should coughing and shou have received the c who gave her the w	check on residents who are ld get a nurse. R5 should correct diet and did not know rong diet.				
		on 9/25/20, at 1:40 p.m. orted both dietary and nursing trays.				
	stated a resident is upgraded texture if been signed. The re order from the phys	on 9/25/20, at 3:06 p.m. RN-B ok to be provided an a risk and benefit form had esident should be given the sician if there is no signed risk 5 did not have a signed form.				
	should have receive	p.m. Cook-A- stated R5 ed the ordered diet, but did sponsible for providing the				
	and Benefits policy resident would be in benefits of necessa opportunity regardin care. The resident times and if resider documentation sho	of Care/Interventions, Risk dated 9/11, identified a nformed of the risk and ary care and given the ng their decision in the plan of would be approached 2-3 nt continued to refuse, uld be made on the Refusal of				
	reviewed quarterly.	Risk and Benefits and nagia Diet indicated NDD2 as				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00568		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/28/2020	
					09/	20/2020
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	IATE, ZIP CODE		
PLEASA	NT MANOR LLC		JLT, MN 55021	1		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLET DATE
				DEFICIENC	Y)	
2 830	Continued From pa	ge 38	2 830			
	Dysphagia Mechan	ically Altered. All foods on				
		. Meats and other select				
		nd or minced into small pieces				
		orth inch. All food items				
		hew. Meats should be or cooked meat, poultry, or				
	0	or tender meat may be served				
		. Breads products can be				
		s, moistened bread crumbs				
		that are gelled through entire				
		t and to avoid all other bread				
		es should be soft, well-cooked				
		ables should be less than 1/2 easily mashed with a fork.				
		easily mashed with a lork.				
	SUGGESTED MET	HOD OF CORRECTION:				
		sing or designee, could				
		es and procedures related to				
		resident supervision to assure	•			
		and interventioins are being				
	•	ne provider is promptly notified				
		lition. They could re-educate and procedures. A system				
		nonitoring consistent				
		hese policies could be				
		results of these audits being				
		ty's Quality Assurance				
	Committee for revie	ew.				
	TIME PERIOD FOR	R CORRECTION: Twenty-one				
	(21) days.	,				
2 905	MN Rule 4658.0525	5 Subp. 4 Rehab - Positioning	2 905			
	Subn 4 Positionin	g. Residents must be				
		body alignment. The position				
		to change their own position				
		t least every two hours,				
		-				

Minneso	ota Department of He	alth			FORM	IAPPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED
		00568	B. WING			C 28/2020
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PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 905	including periods of been put to bed for has documented th hours during this tir	ge 39 f time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or rdered a different interval.	2 905			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide repositioning timely for 1 of 3 residents (R4) reviewed who were at risk of developing pressure ulcers.					
	dated 8/27/20, incluing impairment with a crequired extensive total staff assistance	inge Minimum Data Set (MDS) ided severe cognitive liagnosis of dementia. R4 assist for bed mobility and e for transfer. R4 was at risk levelopment, but did not have ulcer.				
	(CAA) dated 8/28/2 for pressure r/t [rela with bed mobility ar incontinence. Resic down r/t cognitive in HTN [hypertension] and daily use of AS [blood thinner]. She bladder. Resident r over skin tear on LI otherwise intact. Pr place with toileting hours, pressure rec wheelchair and mat	Care Area Assessment 0 included, "Resident triggers ated to] need for assistance of bowel and bladder dent is at risk for skin break mpairment, dx [diagnosis] of and Type 2 DM [diabetes] A [aspirin] and Coumadin e is incontinent of bowel and noted to have scabbed area LE [lower left extremity]. Skin eventative skin measures in and repositioning q [every] 2 distribution cushion to ttress to bed, routine skin [morning] and HS [night], and				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVE COMPLETED	
		00568	B. WING		09/	28/2020
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PLEASA	NT MANOR LLC		D AVENUE LT, MN 55021	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From page 40 weekly skin inspections."		2 905			
	alteration in skin int "Monitor skin integr inspection by nurse order. Pressure red Pressure redistribut chair." Care plan in R4's care plan furth mobility related to e "Dependent with be staff]. Maxi lift (Hoy transfers. Turn and hours]." Additionally "Alteration in comfo 9/8/20: "Position q2 [as needed] with pil R4's nursing assista "Assist of 2 w/ [with not ambulate." The	d 6/26/20 included, "Potential egrity." Staff were directed to, ity daily. Weekly skin . Treatment to open areas per listribution mattress to bed. tion cushion to wheelchair, terventions updated 9/1/20. er indicated, "Alteration in end of life" with interventions: ed mobility: A1-2 [assist of 1-2 er) [mechanical lift] with reposition Q2H [every 2 / R4's care plan specified, ort," with an intervention dated thrs [every 2 hours] and PRN lows for comfort." ant Care Sheet included,] Hoyer [mechanical lift]; does e care sheet did not direct staff sist R4 with turning and				
		/isit progress note dated bes verbalize some discomfort				
	starting at 10:25 a.r herself in the wheel effectively adjust he members asked R4 R4 verbally decliner offered to recline R declined. No encou	observation on 9/25/20, n. R4 was attempting to adjust chair, but was not able to erself. At 10:34 a.m. 2 staff I if she would like to lay down. d. The 2 staff members 4's wheelchair. R4 verbally ragement or re-approach was onal attempts to reposition				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00568	B. WING			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PLEASA	NT MANOR LLC		ND AVENUE JLT, MN 55021	I		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 905	Continued From pa	ge 41	2 905			
	repositioned. LPN-I room. At 1:55 p.m. NA-B assisted R4 ii bed using 2 pillows	er insulin. R4 was not D brought R4 to the dining nursing assistant (NA)-F and nto bed and positioned her in . As R4 was laid in bed she at hurts." R4 specified that the k.				
	and NA-B stated th morning cares at 7: not had time to ass since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge the same position in	on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or reposition o at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours in her chair without being hould be repositioned every 2	1			
		on 9/28/20, at 3:05 p.m. the (DON) stated R4 should be 2 hours.				
	5/2013) identified, " resident who is imn for repositioning." T "Residents who are every 1 hour (q1 ho Residents who are an every 2 hour (q2 schedule." Facility p Wound Manageme	epositioning (revision date Repositioning is critical for a nobile or dependent upon staff The policy further instructs, a in a chair should be on an our) repositioning schedule. in bed should be on at least thour) repositioning policy Skin Assessment and nt (revision date 7/2018) skin inspection will be sed staff."	F			
		HOD OF CORRECTION:				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00568	B. WING			09/28/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
PLEASA	NT MANOR LLC		D AVENUE LT, MN 55021	I			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 905	Continued From pa	ge 42	2 905				
	all residents at risk they are receiving th treatment/services of from developing and pressure ulcers. Th designee, could cor delivery of care; to e services are implen pressure ulcer devel	ing or designee, could review for pressure ulcers to assure the necessary repositioning to prevent pressure ulcers d to promote healing of the director of nursing or induct random audits of the ensure appropriate care and thented; to reduce the risk for elopment.					
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920				
	comprehensive resi home must ensure B. a resident who activities of daily livi	is unable to carry out ing receives the necessary n good nutrition, grooming,					
	by: Based on observati review, the facility fa care timely, and fail status after a signifi	ent is not met as evidenced on, interview, and document ailed to provide incontinence ed to reassess continence cant change for 1 of 3 ewed for incontinence.					
	Findings include:						
	6/29/20, included, n with diagnoses inclu	imum Data Set (MDS) dated noderate cognitive impairment uding diabetes, dementia and ed extensive assistance with					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
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2 920	Continued From pa	ge 43	2 920				
	hygiene. R4 was n	assistance with personal ot on a toileting program and continent of urine (less than 7 sessment period).					
	dated 7/1/20 indica urinary incontinence assistance with toil incontinence." "She and OT [occupation the goal of returning uses incontinence p dry. Plan to continu and complete period	Care Area Assessment (CAA) ted, "Resident triggers for e r/t [related to] need for et use and bladder e is in PT [physical therapy] nal therapy] at this time with g to the community. Resident products to aid in keeping skin e to with current toileting plan cares q [every] AM [morning], n each incontinent episode."					
	included severe co dependent upon sta	inge MDS dated 8/27/20, gnitive impairment, was totally aff for toileting and personal ways incontinent of urine.					
	"Resident triggers f toilet use and bladd declined in both mo She has recently er life cares. Resident aid in keeping skin current toileting pla	CAA dated 8/28/20 included, for urinary incontinence r/t der incontinence. Resident has obility and cognitive function. Arrolled in hospice for end of t uses incontinence products to dry. Plan to continue to with n and complete peri cares q g], HS [night], and with each a."					
	medical record was	d Bladder assessment in the dated 6/24/20, and indicated f bowel and bladder.					
nnesota D	"Alteration with elim	ed 6/26/20, included, nination." Staff were directed toileting." The care plan had					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
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PLEASA	NT MANOR LLC		D AVENUE LT, MN 5502 [,]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETI DATE
2 920	Continued From pa	ige 44	2 920			
	8/27/20, MDS noted incontinence to total	ince 6/26/20, even though the d a decline in urinary ally incontinent and an increase s for toileting and personal				
	R4's nursing assistant Care Sheet included, "Assist of 2 w/ Hoyer [mechanical lift]; does not ambulate." No information was included to direct nursing assistants on how to attend to R4's toileting needs.					
	starting at 10:34 a.n if she would like to declined. No encour provided. No addition incontinence cares licensed practical n her room to check insulin. LPN-D then room. Incontinence	observation on 9/25/20, m. 2 staff members asked R4 lay down. R4 verbally iragement or re-approach was onal attempts to provide occurred. At 11:46 a.m. turse (LPN)-D brought R4 to blood sugar and administer a brought R4 to the dining cares were not provided. At d NA-B assisted R4 into bed visibly wet brief.				
	and NA-B stated th morning cares at 7: not had time to ass since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge	on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with :30 a.m. NA-F stated they had ist R4 to lie down or toilet o at 7:30 a.m. NA-F stated, o f us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and od R4 had gone 6.5 hours ted with incontinence cares.				
	director of nursing should be assisted	on 9/28/20, at 3:05 p.m. the (DON) stated, she thought R4 with incontinent cares every 2 tated she did not know R4's				

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 09/28/2020	
		00568	B. WING			
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PLEASA	ANT MANOR LLC		D AVENUE ILT, MN 55021	I		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	needs very well. Re was present review and Bladder assess 6/24/20, noting it ind bladder. RN-A revie identified R4 had no Bladder assessmer significant decline in June of 2020. RN-, an updated assess change MDS comp explained they were R4 was on their wor should have been of changed at least ev The facility policy To 11/2019) identified, incontinence produc change as needed. Planning" (revision care plan is to be m condition and care to changes." SUGGESTED MET The director of nurs review and revise p responsible staff to dependant on faciliti comprehensively as designee could con resident cares to er needs are met time	egistered nurse (RN)-A who ved R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and ot had an updated Bowel and nt, even though she had a n condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4 hecked for incontinence and ery 2 hours. bileting Assistance (policy date "If a client wears an ct, check if soiled or wet and " The facility policy Care date 6/2019) identified "The nodified and updated as the needs of the resident "HOD OF CORRECTION: ing and/or designee could rocedures and educate provide care to residents' sy staff, based on residents' ssessed needs. The DON or duct audits of dependent asure their personal care				

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NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE					
PLEASA	NT MANOR LLC		ID AVENUE JLT, MN 5502 [,]	1				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
21810	Continued From pa	ige 46	21810					
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810					
	residents shall have medical and persor needs. Appropriate care designed to er highest level of phy This right is limited	riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means hable residents to achieve their visical and mental functioning. where the service is not blic or private resources.						
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview, and document ailed to provide care in a ted dignity for 1 of 1 resident ignity concerns.						
	Findings include:							
	7/28/20, included m with a diagnosis of incontinent and req	nimum Date Set (MDS) dated noderate cognitive impairment a stroke. R7 was occasionally uired assistance by one staff on and off of the toilet.						
	Rehab Care Assest dated 9/25/20, inclu decline in mobility,	of daily living)/Functional sment Area Worksheet (CAA) uded, R7 has had a recent was occasionally incontinent er, and needed assistance for est.						
	required assistance dependent assist, c	ed 7/29/20, included, R7 e for, "Bathing with max to dressing with max assist, et-up with minimal assist,						

If continuation sheet 47 of 49

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUR COMPLETE	
		00568	B. WING			28/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	NT MANOR LLC		D AVENUE LT, MN 5502 ²	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21810	Continued From pay occasionally inconti with toilet use."	ge 47 nent, and requires assistance	21810			
	When Interviewed of was lying in bed. R7 facility is very bad. I there seems to be r facility. Call lights ca hour. I push the call bathroom and no or wet myself. I feel hi chair and embarras cleaned up and cha brow was furled and R7 stated this happ When interviewed of nursing assistant (N wait for assistance to her incontinent. This Most residents wait time to receive an a has assisted R7 afte secondary to waiting time for the call ligh that there have bee beginning of the shi soiled and need ass night shift is custom one licensed praction nurse (RN) for the 4 facility. When interviewed of LPN-D state there is individual needs of a among staff and res	on 9/25/20, at 2:00 p.m. R7 ' stated, "Staffing for the blame the State because to staffing guidelines for this an go unanswered for over an light when I need to go to the ne comes until it is too late. I umiliated about wetting in the sed about needing to be nged." R7 looked angry, her d her face became slightly red. ens at least once a week. on 9/25/20, at 2:35 p.m. IA)-D stated R7's often has to to the bathroom which makes is was always upsetting to R7. for an extended period of nswer to their call light. NA-D er R7 was incontinent g for a prolonged period of t to be answered. NA-D stated n, "too many times," at the fit when several residents are sistance. NA-D stated the harily staffed with two NA's and cal nurse (LPN) or registered 42 current residents in the on 9/25/20, at 2:55 p.m. is insufficient staff to meet the each resident. The morale sidents is low because of this. It due to not being able to get mity issue				

If continuation sheet 48 of 49

STATEME	ota Department of He NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00568	B. WING			C 28/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
PLEASA	ANT MANOR LLC					
			JLT, MN 5502 ⁻			()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	ge 48	21810			
	 9/22/20, at 3:51 a.m showed the call ligh the seven day period initiated, 11 (or 21.5 15 minutes to receive 14%) of these alerts to receive a response During a phone call p.m. the administration staffing or facility as determining staffing administrator stated include one staff me "More comradery and was needed among 	interview on 9/28/20, at 3:30 tor stated they do not have a seessment in place to assist in place to assist in place to assist in current staffing rations ember for every ten residents. Ind better communication," the staff. These measures the administrator stated that				
	The administrator, of designee could revi- ensure residents re timely fashion. It co residents that may l concern. The facility changes, and audit needs of resident(s audits for an amour quality assessment improvement (QAP compliance. The ac could then take that assess need for fur	I) committee could ensure Iministrator, DON, or designee t information back to QAPI to				

		AND HUMAN SERVICES			FORM	APPROVED
						0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
			/		(C
		245090	B. WING _		09/2	28/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		BE	COMPLETION DATE
TAG	REGULATORT OR L	SCIDENTIFTING INFORMATION)	TAG	DEFICIENCY)		
			1			
F 000	INITIAL COMMENT	rs	F 00	00		
	· ·	0 and 9/28/20, an abbreviated ted at your facility to conduct a				
		tion. Your facility was found				
		ance with 42 CFR Part 483,				
	Requirements for L	ong Term Care Facilities.				
	The following comp	laints were found to be				
	substantiated:	0				
	H5090056C at F68 H5090057C at F67					
	H5090059C at F67					
	The following comp	Jointo woro found to be				
		plaints were found to be I5090055C and H5090058C.				
		f correction (POC) will serve of compliance upon the				
		ptance. Because you are				
	enrolled in ePOC, y	our signature is not required				
		e first page of the CMS-2567 ic submission of the POC will				
	be used as verificat					
	Upon receipt of an	acceptable electronic POC, an				
		ur facility may be conducted to Intial compliance with the				
		en attained in accordance with				
	your verification.					
F 550	0		F 55	50		
SS=D	CFR(s): 483.10(a)(1)(2)(0)(1)(2)				
	§483.10(a) Resider					
		right to a dignified existence,				
		and communication with and and services inside and				
	outside the facility,	including those specified in				
	this section.					

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

TITLE

(X6) DATE

PRINTED: 10/13/2020

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.

		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	§483.10(a)(1) A fact with respect and dig resident in a manner promotes maintena her quality of life, re- individuality. The fac- promote the rights of §483.10(a)(2) The faccess to quality ca- severity of condition must establish and practices regarding provision of service- residents regardless §483.10(b) Exercise The resident has th- rights as a resident or resident of the Uf §483.10(b)(1) The f resident can exercise interference, coercid from the facility. §483.10(b)(2) The r free of interference, reprisal from the fac- rights and to be sup exercise of his or he subpart. This REQUIREMEN by: Based on observat review, the facility fac-	 ility must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and of the resident. facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the s under the State plan for all s of payment source. e of Rights. e right to exercise his or her of the facility and as a citizen nited States. facility must ensure that the se his or her rights without on, discrimination, or reprisal resident has the right to be , coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this NT is not met as evidenced tion, interview, and document ailed to provide care in a ted dignity for 1 of 1 resident 	F 5	550			

		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	ROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 550	Continued From pa Findings include:	ge 2	F٤	550			
	7/28/20, included m with a diagnosis of incontinent and req	imum Date Set (MDS) dated noderate cognitive impairment a stroke. R7 was occasionally uired assistance by one staff on and off of the toilet.					
	Rehab Care Assess dated 9/25/20, inclu decline in mobility,	of daily living)/Functional sment Area Worksheet (CAA) ided, R7 has had a recent was occasionally incontinent er, and needed assistance for est.					
	required assistance dependent assist, d personal hygiene se	d 7/29/20, included, R7 e for, "Bathing with max to ressing with max assist, et-up with minimal assist, inent, and requires assistance					
	was lying in bed. R facility is very bad. I there seems to be r facility. Call lights c hour. I push the cal bathroom and no of wet myself. I feel h chair and embarras cleaned up and cha brow was furled and	on 9/25/20, at 2:00 p.m. R7 7 stated, "Staffing for the I blame the State because no staffing guidelines for this an go unanswered for over an I light when I need to go to the ne comes until it is too late. I umiliated about wetting in the seed about needing to be anged." R7 looked angry, her d her face became slightly red. wens at least once a week.					
	nursing assistant (N wait for assistance	on 9/25/20, at 2:35 p.m. NA)-D stated R7's often has to to the bathroom which makes s was always upsetting to R7.					

If continuation sheet Page 3 of 61

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Most residents wait time to receive an a has assisted R7 aft secondary to waitin time for the call ligh that there have bee beginning of the shi soiled and need as night shift is custom one licensed practic nurse (RN) for the 4 facility. When interviewed of LPN-D state there i individual needs of among staff and res R7 being incontinent to her timely is a dig R7's call light respon 9/22/20, at 3:51 a.n showed the call ligh the seven day period initiated, 11 (or 21.5 15 minutes to receind 14%) of these alerts to receive a respon During a phone call p.m. the administra staffing or facility as determining staffing administrator stated include one staff me "More comradery a was needed among	for an extended period of answer to their call light. NA-D er R7 was incontinent g for a prolonged period of it to be answered. NA-D stated in, "too many times," at the iff when several residents are sistance. NA-D stated the narily staffed with two NA's and cal nurse (LPN) or registered 42 current residents in the on 9/25/20, at 2:55 p.m. s insufficient staff to meet the each resident. The morale sidents is low because of this. It due to not being able to get gnity issue. Inse time logs dated from n. to 9/28/20, 9:25 a.m. It was engaged 51 times over od. Of the 51 call light alerts 5%) of these alerts took over ve a response. Seven (or s took longer than 20 minutes se. Interview on 9/28/20, at 3:30 tor stated they do not have a ssessment in place to assist in g needs at this time. The d current staffing rations ember for every ten residents. In better communication," g the staff. These measures a. The administrator stated that	F 5	550			

If continuation sheet Page 4 of 61

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245090	B. WING	i			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625 SS=D		Policy Before/Upon Trnsfr 1)(2)	Fe	625	5		
	§483.15(d) Notice c	f bed-hold policy and return-					
	nursing facility trans the resident goes of nursing facility musi- the resident or resident specifies- (i) The duration of the any, during which the return and resume to facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing fac- bed-hold periods, w paragraph (e)(1) of resident to return; a	e before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the t provide written information to lent representative that the state bed-hold policy, if the resident is permitted to residence in the nursing payment policy in the state 0 of this chapter, if any; lity's policies regarding hich must be consistent with this section, permitting a nd specified in paragraph (e)(1)					
	of this section. §483.15(d)(2) Bed-I the time of transfer hospitalization or th facility must provide resident representa specifies the duration described in paragr This REQUIREMEN by: Based on document facility failed to issue	hold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section. JT is not met as evidenced ht review and interview, the e a written bed-hold notice hospital for 1 of 3 residents					

If continuation sheet Page 5 of 61

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625 F 677 SS=D	5/20/20, indicated F 5/14/20 with a disch anticipated MDS da R1's progress note included, R1 was tra full report was given teams. However a b in R1's medical reco When interviewed of guardian reported s bed hold notification possibility to hold th When interviewed of interim director of n bed hold notice was Facility policy titled, Emergency revised bullet number 4: "Th responsible for: b. or her representativ readmission appeal ect." ADL Care Provided CFR(s): 483.24(a)(2) §483.24(a)(2) A res out activities of daily services to maintain personal and oral h This REQUIREMEN by: Based on observat	imum Data Set (MDS) dated A1 was admitted to facility on harge assessment-return ited, 9/16/20. dated 9/16/20, at 6:24 p.m. ansferred to the hospital and a n to the police and transport bed hold notice was not found ord. on 9/24/20, at 3:07 p.m. R1's he had not been provided a n and was unaware of the e bed for R1. on 9/28/20, at 2:09 p.m. the ursing (DON) verified a written a not completed for R1. Transfer or Discharge, on 08/2018, indicated under ne business office is Informing the resident, or his e (sponsor) of our facility's i rights, bed-holding policies, for Dependent Residents 2) ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview, and document	F 6				
		ion, interview, and document ailed to provide incontinence					

If continuation sheet Page 6 of 61

		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	status after a signifi residents (R3) revie Findings include: R4's admission Min 6/29/20, included, n with diagnoses inclu arthritis. R4 require toileting and limited hygiene. R4 was n was occasionally in times during the as R4's incontinence C dated 7/1/20 indicat urinary incontinence assistance with toile incontinence." "She and OT [occupation the goal of returning uses incontinence p dry. Plan to continu and complete peri of HS [night], and with R4's significant chai included severe cog dependent upon sta hygiene and was al R4's incontinence C	led to reassess continence icant change for 1 of 3 ewed for incontinence. himum Data Set (MDS) dated noderate cognitive impairment uding diabetes, dementia and ed extensive assistance with assistance with personal ot on a toileting program and continent of urine (less than 7 sessment period). Care Area Assessment (CAA) ted, "Resident triggers for e r/t [related to] need for	F	677			
	She has recently er life cares. Resident	bility and cognitive function. nrolled in hospice for end of uses incontinence products to dry. Plan to continue to with					

If continuation sheet Page 7 of 61

DEPARTMENT OF HEALTH					FORM	10/13/2020 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
	245090	B. WING				_ 28/2020
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASANT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
 [every] AM [morning incontinent episode. R4's only Bowel and medical record was R4 was continent of R4's care plan dated "Alteration with elimit to, "Assist of 1 with the not been updated site 8/27/20, MDS noted incontinence to total in assistance needs hygiene. R4's nursing assista "Assist of 2 w/ Hoye ambulate." No informor nursing assistants of toileting needs. During continuous of starting at 10:34 a.m if she would like to be declined. No encour provided. No additionincontinence cares of licensed practical nu- her room to check be insulin. LPN-D then room. Incontinence of 1:58 p.m. NA-F and and changed R4's view 	and complete peri cares q], HS [night], and with each " Bladder assessment in the dated 6/24/20, and indicated bowel and bladder. d 6/26/20, included, ination." Staff were directed toileting." The care plan had nce 6/26/20, even though the a decline in urinary ly incontinent and an increase for toileting and personal ant Care Sheet included, r [mechanical lift]; does not mation was included to direct n how to attend to R4's bservation on 9/25/20, n. 2 staff members asked R4 ay down. R4 verbally ragement or re-approach was nal attempts to provide occurred. At 11:46 a.m. urse (LPN)-D brought R4 to lood sugar and administer brought R4 to the dining cares were not provided. At NA-B assisted R4 into bed	F	677			

If continuation sheet Page 8 of 61

STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIER/LUA IDENTIFICATION NUMBER: 245090 (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURPEY COMPLETE OUTCOMPLETE BUILDING (X3) DATE SURPEY COMPLETE OUTCOMPLETE DESCRIPTION NUMBER: 1 STREET ADDRESS, CITY, STATE, 21P CODE (X3) DATE SURPEY COMPLETE OUTCOMPLETE DESCRIPTION STREET ADDRESS, CITY, STATE, 21P CODE (X4) DATE SURPEY COMPLETE OUTCOMPLETE DESCRIPTION STREET ADDRESS, CITY, STATE, 21P CODE (X4) DATE SURPEY COMPLETE DESCRIPTION STREET ADDRESS, CITY, STATE, 21P CODE (X4) DATE SURPEY COMPLETE DESCRIPTION (X4) DATE SURPEY COMPLETE DESCRIPTION (X5) DATE SURPEY COMPLETE DESCRIPTION<			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391			
245090 B. WING	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	COMPLETED				
27 BRAND AVENUE FARIBAULT, MN 55021 (x4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG OCMMETER (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMETER DEFICIENCY F 677 Continued From page 8 not had time to assist At to lie down or toilet since getting her up at 7:30 a.m. NA-F stated, "There are only two of us on the floor, we try our best, it is terrible." NA-B stated, "It's really terrible we can't get to her, we should be." NA-F without being assisted with incontinence cares. F 677 When interviewed on 9/28/20, at 3:05 p.m. the director of nursing (DON) stated, she thought R4 should be assisted with incontinent cares every 2 hours. The DON stated she did not know R4's needs very well. Registered nurse (RN)-A who was present reviewed R4's most recent Bowel and Bladder assessment, which was dated 6/24/20, noting it indicated R4 was continent of bladder. RN-A reviewed R4's most recent Bowel and Bladder assessment, even though she had a significant decline in condition since admission in June of 2020. RN-A stated R4 should have had an updated assessment, with the significant change MDS completed in August 2020. RN-A ID ID			245090	B. WING							
PARIBAULT, MN 55021 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDEN'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 000 F 677 Continued From page 8 not had time to assist R4 to lie down or toilet since getting her up at 7:30 a.m. NA-F stated, "There are only two of us on the floor, we try our best, it is terrible." NA-B stated, "It's really terrible we can't get to her, we should be." NA-F and NA-B acknowledged R4 had gone 6.5 hours without being assisted with incontinence cares. F 677 When interviewed on 9/28/20, at 3:05 p.m. the director of nursing (IDON) stated, she thought R4 should be assisted with incontinent cares every 2 hours. The DON stated she did not know R4's needs very well. Registered nurse (RN)-A who was present reviewed R4's most recent Bowel and Bladder assessment, which was dated 6/24/20, noting it indicated R4 was continent of bladder. RN-A reviewed R4's medical record and identified R4 had not had an updated Bowel and Bladder assessment, even though she had a significant decline in condition since admission in June of 2020. RN-A stated R4 should have had an updated assessment with the significant change MDS completed in August 2020. RN-A	NAME OF F	PROVIDER OR SUPPLIER									
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC DATE F 677 Continued From page 8 not had time to assist R4 to lie down or toilet since getting her up at 7:30 a.m. NA-F stated, "There are only two of us on the floor, we try our best, it is terrible." NA-B stated, "It's really terrible we can't get to her, we should be." NA-F and NA-B acknowledged R4 had gone 6.5 hours without being assisted with incontinence cares. F 677 When interviewed on 9/28/20, at 3:05 p.m. the director of nursing (DON) stated, she thought R4 should be assisted with incontinent cares every 2 hours. The DON stated she did not know R4's needs very well. Registered nurse (RN)-A who was present reviewed R4's most recent Bowel and Bladder assessment, which was dated 6/24/20, noting it indicated R4 was continent of bladder. RN-A reviewed R4's medical record and identified R4 had not had an updated Bowel and Bladder assessment, which was dated a significant decline in condition since admission in June of 2020. RN-A stated R4 should have had an updated assessment with the significant change MDS completed in August 2020. RN-A	PLEASA	NT MANOR LLC									
 not had time to assist R4 to lie down or toilet since getting her up at 7:30 a.m. NA-F stated, "There are only two of us on the floor, we try our best, it is terrible." NA-B stated, "It's really terrible we can't get to her, we should be." NA-F and NA-B acknowledged R4 had gone 6.5 hours without being assisted with incontinence cares. When interviewed on 9/28/20, at 3:05 p.m. the director of nursing (DON) stated, she thought R4 should be assisted with incontinent cares every 2 hours. The DON stated she did not know R4's needs very well. Registered nurse (RN)-A who was present reviewed R4's most recent Bowel and Bladder assessment, which was dated 6/24/20, noting it indicated R4 was continent of bladder. RN-A reviewed R4's most recent Bowel and Bladder assessment, even though she had a significant decline in condition since admission in June of 2020. RN-A stated R4 should have had an updated assessment with the significant change MDS completed in August 2020. RN-A 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION			
 explained they were behind on assessments and R4 was on their work list, "to be caught up." R4 should have been checked for incontinence and changed at least every 2 hours. The facility policy Toileting Assistance (policy date 11/2019) identified, "If a client wears an incontinence product, check if soiled or wet and change as needed." The facility policy Care Planning" (revision date 6/2019) identified "The care plan is to be modified and updated as the condition and care needs of the resident changes." F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) 	F 686	not had time to ass since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge without being assist When interviewed of director of nursing (should be assisted hours. The DON st needs very well. Re was present review and Bladder assess 6/24/20, noting it in bladder. RN-A revie identified R4 had no Bladder assessmen significant decline in June of 2020. RN-7 an updated assess change MDS comp explained they were R4 was on their wo should have been of change at least ew The facility policy To 11/2019) identified, incontinence produc change as needed. Planning" (revision care plan is to be m condition and care changes." Treatment/Svcs to l	ist R4 to lie down or toilet o at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. on 9/28/20, at 3:05 p.m. the DON) stated, she thought R4 with incontinent cares every 2 tated she did not know R4's egistered nurse (RN)-A who ved R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and ot had an updated Bowel and nt, even though she had a in condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4 checked for incontinence and very 2 hours. bileting Assistance (policy date "If a client wears an ct, check if soiled or wet and " The facility policy Care date 6/2019) identified "The nodified and updated as the needs of the resident Prevent/Heal Pressure Ulcer								

If continuation sheet Page 9 of 61

		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From pa	ge 9	F6	686			
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer with professional st promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review, the facility fa timely for 1 of 3 res were at risk of deve Findings include: R4's significant cha dated 8/27/20, inclu impairment with a c required extensive total staff assistanc for pressure ulcer of a current pressure ulcer (CAA) dated 8/28/2 for pressure r/t [rela with bed mobility ar incontinence. Resid down r/t cognitive ir	sure ulcers. prehensive assessment of a must ensure that- res care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and pressure ulcers receives and ards of practice, to revent infection and prevent veloping. NT is not met as evidenced tion, interview, and document ailed to provide repositioning idents (R4) reviewed who eloping pressure ulcers. ange Minimum Data Set (MDS) uded severe cognitive diagnosis of dementia. R4 assist for bed mobility and the for transfer. R4 was at risk levelopment, but did not have					

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		AND HUMAN SERVICES			FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245090	B. WING			C 28/2020
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	and daily use of AS [blood thinner]. She bladder. Resident r over skin tear on LI otherwise intact. Pr place with toileting a hours, pressure rec wheelchair and mai cares q [every] AM weekly skin inspect R4's care plan date alteration in skin int "Monitor skin integr inspection by nurse order. Pressure red Pressure redistribut chair." Care plan in R4's care plan furth mobility related to e "Dependent with be staff]. Maxi lift (Hoy transfers. Turn and hours]." Additionally "Alteration in comfo 9/8/20: "Position q2 [as needed] with pil R4's nursing assists "Assist of 2 w/ [with not ambulate." The on how often to ass repositioning. A Hospice Facility N 9/3/20 included, "De to bottom."	A [aspirin] and Coumadin e is incontinent of bowel and noted to have scabbed area LE [lower left extremity]. Skin reventative skin measures in and repositioning q [every] 2 distribution cushion to ttress to bed, routine skin [morning] and HS [night], and tions." ed 6/26/20 included, "Potential tegrity." Staff were directed to, rity daily. Weekly skin e. Treatment to open areas per distribution mattress to bed. tion cushion to wheelchair, terventions updated 9/1/20. her indicated, "Alteration in end of life" with interventions: ed mobility: A1-2 [assist of 1-2 ver) [mechanical lift] with I reposition Q2H [every 2 y R4's care plan specified, ort," with an intervention dated 2hrs [every 2 hours] and PRN	F 68	,		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATI COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	starting at 10:25 a.r herself in the wheel effectively adjust he members asked R4 R4 verbally decliner offered to recline R declined. No encou provided. No additio occurred. At 11:46 a (LPN)-D brought R4 sugar and administ repositioned. LPN-I room. At 1:55 p.m. NA-B assisted R4 in bed using 2 pillows stated, "Oh God, th pain was in her bac When interviewed of and NA-B stated the morning cares at 7: not had time to ass since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge the same position in repositioned. R4 sh hours. When interviewed of director of nursing (repositioned every 3 The facility policy R 5/2013) identified, " resident who is imm	n. R4 was attempting to adjust chair, but was not able to erself. At 10:34 a.m. 2 staff 4 if she would like to lay down. d. The 2 staff members 4's wheelchair. R4 verbally ragement or re-approach was onal attempts to reposition a.m. licensed practical nurse 4 to her room to check blood er insulin. R4 was not 0 brought R4 to the dining nursing assistant (NA)-F and nto bed and positioned her in . As R4 was laid in bed she at hurts." R4 specified that the k. on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or reposition o at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours in n her chair without being nould be repositioned every 2	F	586			

Facility ID: 00568

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COMI	E SURVEY PLETED
		245090	B. WING _			(09/2	28/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 686 F 689 SS=G	"Residents who are every 1 hour (q1 ho Residents who are an every 2 hour (q2 schedule." Facility p Wound Managemen identified "A weekly completed by licens Free of Accident Ha CFR(s): 483.25(d)(1) §483.25(d) Accident The facility must en §483.25(d)(1) The r as free of accident H §483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility fa assess 3 of 5 resid had fallen, and impl prevent further falls for R1 when she su and fractured her sl failed to ensure 2 or reviewed for chokin ordered modified te Findings include: R1's quarterly Minin 8/20/20, included, s with diagnoses inclu	in a chair should be on an bur) repositioning schedule. in bed should be on at least thour) repositioning policy Skin Assessment and nt (revision date 7/2018) skin inspection will be sed staff." azards/Supervision/Devices 1)(2) tts. usure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview and document ailed to comprehensively lents (R1, R4, and R3) who lement interventions to . This resulted in actual harm istained 19 falls, broke a finger kull. In addition, the facility f 5 residents (R10 and R5) ing risk were served the	F 68	36			

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	assistance with mo (ADL's) and did not falls with injury sinc had a discharge MI R1's falls Care Area included, "Resident having impaired ba medication use. Re following hospitaliza infection] and increa involved in a MVA [I November and suff including but not lim rib fractures, and w increased risk for fa agitation, and daily anticonvulsant, anti benzodiazepine me of bowel and bladde history of falls prior any falls since adm to a room closer to Plan to continue to light in reach, and fi recommendations." would be addressed R1's admission Fall 5/19/20, included a falls as identified in there was no analys identification of inte reduce the chance R1's care plan date AEB [as evidenced admission related to	st activities of daily living ambulate. R4 had 2 or more e the prior assessment. R1 DS dated 9/16/20. Assessment dated 5/22/20, triggers for falls r/t [related to] lance and daily psychotropic esident has decreased mobility ation for a UTI [urinary tract ased behaviors. Resident was motor vehicle accident] last ered multiple major injuries nited to: skull fractures, TBI, rist fractures." "Resident is at alls r/t cognitive impairment, use of psychotropic, hypertensive, and edications. She is incontinent er. She does not have a to admission and has not had ission. Resident was moved the nurses station for safety. monitor for safety, keep call ollow therapy ' The CAA indicated falls d in the care plan. I Review Evaluation dated check list of risk factors for the 5/22/20 CAA. However, sis of fall risk factors or rventions that may mitigate or	F	589			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245090	B. WING	;			C 28/2020
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	disturbances." The "Resident will be sa should incident occ use one assist for t Place bed on low p both sides of bed. unless providing ca chair for comfort. T in wheel chair. Pro taking outside and y R1's Action Summa identified R1 had fa 7/31/20, 8/1/20, 8/5 8/12/20, 8/16/20, 8/ 8/21/20, 8/29/20, 9/ addition, R1's progr 8/30/20 identified sl not included on the no progress notes as the mat next to the bed 8/5/20, 8/6/20, 8/16 times, 8/29/20, 8/30 identified from a wh 9/15/20. 1 fall from was no documentar circumstances of th 7/14/20, 8/11/12, 8/ 9/14/20. R1's Incident Reviet included, R1 was for Incident Analysis in resident's room and	age 14 e goal for R1 was listed as, afe and free from serious injury cur." Staff were directed to, transfers with a standing lift. toosition. Have fall mats on Leave door open at all times ares. Use a tilt-in-space wheel To be visually supervised when ovide one on one care, such as wheeling her down the hall. ary dated 7/1/20 to 9/28/20, allen 17 times on 7/14/20, 5/20, 8/6/20, 8/11/20, 8/12/20, /16/20, 8/16/20, 8/19/20, /3/20, 9/14/20 and 9/15/20. In ress notes dated 7/29/20 and the had fallen, but these were excition Summary. There were or incident reports for the falls stion Summary which were 2/20 (2 falls), 8/19/20, or the falls were identified in the being a fall from bed onto the d. These were on 7/31/20, 5/20 - three times, 8/21/20-3 0/20, and 9/3/20. 2 falls were neel chair on 8/29/20 and the recliner on 7/29/20. There tion to determine the ne falls that occurred on /11/20, 8/12/20, 8/19/20, or	F	689			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING	i			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	which contributes to diagnosis of unspect consciousness; Det disturbance." The filisted: proper footw (physical therapy/od lowest position and to be visually super Provide tilt-in-space recline resident whe comfort. Staff prov such as taking her down the hall. "Res- times heard yelling, attention to staff an reassurance. Resid lack of safety award dementia. Residen and restlessness at resident's self trans- to tend to her." The to the care plan. R1's progress note [certified nursing as [10:00 a.m.] that res- chair. Upon enterin- sitting on the footre recliner was tilting fi resident back to set R1's progress note 8:40 PM writer heat room and found res- to her bed." Abrasi There was no asse- Interventions addeo resident's bedroom	b resident's fall risks due to cified TBI w/o loss of mentia with behavioral follow-up/intervention section /ear, evaluation by PT/OT ccupational therapy), bed in soft touch call light. Resident vised when in wheelchair. wheelchair with the ability to en in chair to provide ore iding 1:1 (one on one) care outside and wheeling her sident with behaviors and often Resident requires 1:1 d to redirect and provide dent is at high fall risk due to eness due to TBI and t also experiences agitation nd could be the reason of ferring to get staff's attention ese interventions were added dated 7/29/20, included, "CNA sistant] told writer at 1000 sident had slid forward in her ng room writer found resident st of her recliner and the orward. Three staff assisted at [sic] of the chair." dated 7/31/20, included, "At rd resident calling out from her sident on the floor laying next ons were noted to both knees.	F	689			

Facility ID: 00568

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DEPARTMENT OF HEALTH AND HUMAN SERVIC CENTERS FOR MEDICARE & MEDICAID SERVICI				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	LIA (X2) MU		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
245090	B. WING	G			C 28/2020
NAME OF PROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASANT MANOR LLC			7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		IX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
 F 689 Continued From page 16 dark." Keeping the bathroom light on wher room is dark was not added to the care plat R1's Incident Review and Analysis report d 8/5/20, identified R1 was found on the floor 7/31/20. The report identified R1 wanted to out of room." No further assessment of thi was documented. However, a new interve of notifying the nurse practitioner of, "frequ anxiety, agitation, restlessness and requess change in medications to decrease anxiety restlessness, and agitation," was requested R1's Incident Review and Analysis report d 8/5/20, identified R1 had been found on the on 8/1/20. The form identified, "Resident v to get out of room." This listed the same intervention as the 8/5/20 report for the fall 7/31/20. There was no assessment compl regarding this fall. R1's progress note dated 8/6/20, included, "Resident found on floor by bed on knees. out. Asked her what she was doing and sh going to the floor." There was no assessment this. R1's progress note dated 8/16/20, at 3:46 p included, "Writer notified by TMA [trained medication aide] at 1500 [3:00 p.m.] that re was on the floor." R1 was sitting on floor n bed. The note indicated the physician was notified due to increased anxiety and additi antianxiety medication was ordered. R1 in she hurt all over. R1's progress note dated 8/16/20, at 10:28 included, "Aid called writer into room. Resi had knees on ground and torso was still in 	e said ent of p.m. d. eted yelling e said ent of p.m. dicated	689			

Facility ID: 00568

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	bed. Resident was facility." R1's progress note included, "Aid called sitting on floor with was wanting to leav R1's progress note included, "Resident bed. Resident had slid out of her bed. leave facility and ca me out of here." R1's progress note "Writer observed re mat next to bed this at lowest position. happened and reside of here." R1's progress note 2:15 PM writer heat Writer found reside her W/C [wheel cha Writer found 1" [inc forehead. Resident footwear, foot peda incontinence noted.	confused and wanted to leave dated 8/16/20, at 10:35 p.m. d nurse in to find resident arms on the bed. Resident	F	689			
	also. R1's progress note "Writer heard repea room and found res	und an abrasion on her knee dated 8/30/20, included, ated yelling out from resident's sident on the floor next to her west position, call light within					

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING _				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	-	F 68	89			
	reach, fall mats in p resident not inconti	place both sides of bed, and nent."					
	on right index finge There was no incide	dated 8/30/20, noted a bruise r and a scrape on her head. ent report or assessment to ese injuries occurred.					
		dated 8/31/20, included, the updated on bruise to right					
	R1's progress note sore right finger."	dated 9/2/20, included, "Ice to					
	monitor right index	ord identified staff were to finger related to a fall. identify which fall caused this					
	"Writer heard reside when writer arrived floor next to her bee	dated 9/3/20, included, ent yelling from her room and resident was sitting on the d yelling, "Help me get back yest position with fall mats in in reach."					
	there was no comp determine the reaso any pattern in time	Id fallen from bed 13 times, rehensive assessment to on R1 was falling from bed, of day or situation, or to current interventions were not further falls.					
		dated 9/10/20, included, finger related to a fall." "Nail ger appears black."					
	R1's progress note	dated 9//13/20, identified to,					

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		245090	B. WING				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	"Monitor right index "Patients finger com nail bed no redness remains intact at th R1's Incident Revie 9/15/20, identified F wheelchair on 9/15/ cause of R1's fall fr The form identified emergency room for wound. R1's hospital Admis dated 9/15/20, inclu floor in bedroom an herself on floor at n agitated/verbally up upstairs." The rest an acute nondisplat posterial parietal bo hospital discharge s sustained a closed her right hand 2nd f before returning to fracture was in a sta had happened in th an injury to R1's rig progress notes on 8 not assessed by a p hospitalized on 9/15 When interviewed of stated R1 had faller wheel chair, she wa and required one of fall. NA-B stated th on ones with R1. N	finger related to a fall." tinues to be black around the s or warmth noted to site. Nail is time." w and Analysis report dated A1 had fallen from her /20. No assessment of the om the chair was completed. R1 was sent to the or evaluation due to a head asion History and Physical ided, "Patient was found on id then seemed to throw ursing station. She has been set at times. Wanting to go ults from a CT of head noted ced fracture of the left one (skull fracture). R1's summary identified R1 had skull fracture and a fracture of finger which would be splinted the nursing home. The finger age of healing, identifying it e past. The facility identified ht index finger in the the 8/30/20. However, this was ohysician or x-rayed until	F	589			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa and trying to stand sit with her one on a so other residents r When interviewed of stated R1 had faller scream and throw h interventions she ku the low position and R1 did this she wou remembered R1 ha area on her forehea but did not know wh When interviewed of guardian stated the sustaining a fractur undiagnosed for so When interviewed of licensed practical n constantly throwing threatening to throw was not enough sta supervision with R1 any assessment of determine why she was R1's behaviors assessment of R1's she was, "throwing When interviewed of director of nursing (a good system for w are trying to improv	age 20 up all the time, other than to one, winch was not possible required care too. on 9/24/20, at 1:31 p.m. NA-C n frequently, she would herself from bed. The only new of was to have the bed in d mats on the floor so when uldn't be injured. NA-C ad a large swollen egg sized ad and had broken her finger, hen this occurred. on 9/24/20, at 3:07 p.m. R1's ey were concerned about R1 ed finger that went o long. on 9/24/20, at 3:45 p.m. turse (LPN)-B stated R1 was herself off the bed and w herself off the bed. There aff to do one on ones and 1. LPN-A was unable to find R1's falls for pattern or to was falling. LPN-A stated it s, but was unable to find any s behaviors to determine why herself," out of bed.	F 6	589			
	director of nursing (a good system for v are trying to improv	(DON) stated they did not have when someone falls and they					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING	i			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER		-	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	after each fall. The of these for R1's fal sustained on 7/14/2 9/15/20. The DON assessment had no other falls R1 susta issues and really re which they were un was unable to provi determine if there w what interventions r anxiety/behaviors th frequently. No asse	age 21 e DON was only able to find 4 lls, which were for the falls 20, 7/31/20, 8/1/20, and did not know why this ot been filled out for any of the ined. R1 had behavioral equired one on one attention, able to provided. The DON ide any assessment to was a pattern to R1's falls, and may assist R1 with her hat led to her falling so essment had been completed of determine interventions that	F	689	θ		
	included severe cog diagnosis of demen disturbance. R4 rec mobility and dressin for transfer, toileting was totally incontine cares 1-3 times dur R3 had 1 fall withou assessment. R4's fall CAA includ r/t having impaired psychotropic medic declined in both mo She has recently er	quired extensive assist for bed ng and total staff assistance g, and personal hygiene. R4 ent of bladder and rejected ring the assessment period.					

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F 689	of hypoglycemic, ar narcotic, and psych incontinent of bower recent fall from bed for safety and keep R4's care plan date related to [blank]. S lowest position. Cal Follow PT and OT if function." The most "Ambulate to dining walker] support with 120 ft [feet] x1 [with was added 7/22/20 been made. R4's nursing assista "Assist of 2 w/ [with not ambulate; fall m R4's progress note included, "At 7:35 p lying on floor next to agitated/anxious ar stand/yell at staff. F when trying to positi sling so resident as Ax2 [assist of 2 staf fall mat was in plac lowest position; roo lit." "Resident recein Seroquel [antipsych agitation/anxiety an following hour. Hos of nursing], and em notified. Writer and about in-facility fam	Antihypertensive, diuretic, notropic medications. She is all and bladder. She has had a d. Plan to continue to monitor of call light within reach." and 6/26/20 indicated, "Fall risk Staff were directed, "Bed in all light within reach; fall mat. instruction for mobility t recent intervention, g room with FWW [front wheel h CGA [contact guard assist] in 1 staff] with FWW support" . No additional updates had ant Care Sheet included, ant care Sheet included, and care adde found resident o bed. Resident appeared and continued to try and Resident swinging arms at staff tion Hoyer [mechanical lift] asisted back up into bed with aff]. Call light was within reach; are next to bed; bed was in arm was clear of clutter and well ved PRN [as needed]		589			

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F 689	contact thought it w Emergency contact visit tomorrow." When interviewed of registered nurse (R incident report or po fall. R4's care plan R4, as she is no lor When interviewed of family member (FN allowed to visit rela concerned about R would not be able to a visit. No one had possibly visiting to of When interviewed of LPN-D stated R4 has rolling from bed. The to the bed and make reach. LPN-D stated use the call light an intervention. When interviewed of stated, R4 was to h visits after this fall to The DON stated, the meet after each fall plan, and communi increased family visi- communicated to the plans. R3's admission MD	 yould be worth a try; tis going to try and stop for a on 9/28/20, at 10:00 a.m. cN)-A stated there was no ost fall follow-up report on R4's was incorrect about walking nger able to ambulate. on 9/28/20, at 11:35 a.m. 1)-B stated they had not been ted to COVID and was 4's falls. FM-B stated R4 o see them out her window for 1 spoken to them about decrease anxiety. on 9/28/20, at 12:35 p.m. ad fallen a couple times, hey put a mat on the floor next te sure R4 has her call light in ed R4 would not know how to id was unsure why that was an on 9/28/20, at 3:05 p.m. RN-A have increased family window o aide in preventing more falls. in einterdisciplinary team should l, update care sheets and care cate the change, but the 	F	589			

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F 689	including a stroke a extensive staff assi daily living (ADL's), of falls prior to adm admission with no i delusions or halluci R3's falls CAA date triggers for falls r/t h history of falls, and Resident has had a following hospitaliza weakness. He had increased right side OT at this time with community. Reside r/t daily antihyperter and hypoglycemic r of bowel and bladde vision, and hearing of falls prior to adm since admission wh something on the fl monitor for safety, k follow therapy recor would be completed R3's Fall Review Ev included a checklist before admission, f use that can increas deficits, incontinent concerns with balar findings or indicatio factors would be add R3's care plan date related to lack of sa	and dementia. R3 required istance with most activities of was unsteady, had a history ission and had fallen since njury. R3 did not have inations. a 8 8/19/20, included, "Resident having impaired balance, daily antidepressant use. a recent decline in mobility ation for increased overall a CVA [stroke] and has a weakness. He is in PT and a the goal of returning to the ent is at increased risk of falls nsive, psychotropic, diuretic, medications. He is incontinent er. He has impaired cognitive, . Resident does have a history ission and has had one fall here he was reaching for loor. Plan to continue to keep call light in reach, and mmendations. Care planning d. valuation dated 8/15/20, t of risk factors including fall fall after admission, medication se falls, cognition and sensory ce, confined to chair, and nce. There was no analysis of on on how any of these risk	F 6	\$89			

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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 689	and free from falls.' Answer call light pro- for transfers, follow in reach, proper foo- items were in reach R3's progress note included, "Writer wa walked in and saw floor. Resident was eating supper. Aid, resident up using h Resident states that dropped and he we his wheelchair. Re on the chair that wa R3's progress note included, "Resident was at the medicine "Pt [patient] was att RN heard some sou his wheel chair and saw the resident fal R3's progress note "Writer was called b floor. Resident wa and had his hands Resident was sitting sitting up. Resident his wheel chair to g slipped off the bed bed. Resident's vit limits. Resident wa for all transfers."	Staff were directed to, omptly, use a mechanical lift therapy instructions, call light of therapy instructions, call light of therapy instructions, call light of the therapy instructions, call light of the therapy instructions, call light as called into room when aid resident laying prone on the sent to wheelchair and was ADON and writer helped over [mechanical] lift. the was eating and his spoon int to go catch it and fell out of sident states he hit his nose as next to the wheel chair." dated 8/22/20, at 6:55 p.m. s door was open and writer e cart adjacent to the room." empting at self transfers and und that was apparently from no sooner than he turned, he	F 6	89			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
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NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	"Resident was layin	-	F 6	89			
	waiving it in the air. right next to him wit Resident states he his room and using out of his way. Res wheelchair while do there were no cats assessment of R3's room, even though	Residents wheelchair was the breaks unlocked. was chasing the cats out of the handle gripper to get them sident then fell out of oing this." "Resident was told in this facility." There was no is belief there were cats in his R3 had not had hallucinations time of the comprehensive					
	LPN-C stated other care plan, no new ii any of these falls. I any post fall assess The facility had not determine root caus prevent the falls fro increased confusion not assessed other which the family de interdisciplinary tea next day and place that assessment, b R3.	on 9/28/20, at 10:31 a.m. than what was already in the nterventions were added after _PN-C was unable to provide sment for any of these falls. assessed each fall to se, nor place interventions to m happening again. R3 had n after admission, which was than to offer psych services, clined. Normally, the m would assess each fall the new interventions based upon ut this had not been done for					
	DON and RN-A star to provide the docu resident's who had facilities, "Risk man	on 9/28/20, at 11:44 a.m. the ted the facility was not willing mentation related to any of the fallen as it is part of the nagement." They were unable imentation that R1, R4, or					

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F 689	R3's falls had ever assessed to determ prevent further falls A facility policy titled Management, revis procedure for staff a fall, "staff will mor resident's response intervention put in p 72 hours post fall. 2 staff will re-evaluate appropriate to contri interventions. As ne provider will assist not previously ident documented that fa will implement appr prevent serious injube updated to reflee R10's quarterly MD cognitively intact wi lung disease. R10 up assistance with R10's Speech Ther included a diagnosi dysphagia (difficulty throat) and oral pha in the mouth). The risk for aspiration o Recommendations consistency, small (chewing), swallow bite/sip, slow pacing between liquids/sol	been comprehensively nine interventions that may a from occurring. d, Fall Prevention and add 2/2020, indicated follow-up after a resident had sustained nitor and document the e to and the effectiveness of blace to prevent further falls for 2. If resident continues to fall, e the situation and whether it's inue or change the current eeded, the resident's medical reconsider possible causes tified. 5. If it is determined and alls may be unavoidable, staff ropriate interventions to ury from falls. 6. Care plans will ct fall interventions." PS dated 7/14/20, included ith diagnoses of diabetes and required supervision and set eating. rapy evaluation dated 3/26/20, is of pharyngeal phase y swallowing for issues in the ase dysphagia (due to issues e evaluation noted R10 was at		689			

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F 689	R10's nutritional sta identified a risk fact diet. No analysis of completed. R10's care plan dat nutritional alteration meals; had diet res [National Dysphagia ground or are mino- pieces, they are mo and could have req directed to monitor, physician as neede swallowing problem R10's undated nurs included mechanica R10's Nutrition Eva identified a mechar meat. Speech ther all meats ground, u for preference." R10's Oral/Dental E indicated R10 had f During observation was observed to be 12:47 p.m. it was me hamburger patty or hard to eat because	opriate for diet upgrade. atus CAA dated 4/10/20, cor of a mechanically altered f this risk factor was red 4/1/20, included, risk for n related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be ed no larger than 1/4 inch bist, with some cohesion] diet uested puree. Staff were document, and report to the d for signs and symptoms of	F 68			
	desired one. R10 c	led out the burgers and she continued to cough while cked to see if she was alright,				

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F 689	Continued From pa nor did anyone brin	-	F	689			
	R10's lunch tray ticl texture and to provi	ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded					
	aide (DA)-A stated mechanical soft die	on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating.					
	(CK)-A stated, a me ground meat, no br	on 9/25/20, at 1:12 p.m. cook echanical soft diet should have ead or hard vegetables. The responsible to ensure the ed.					
	stated R10 does co unaware R10 did no stated if someone is	on 9/25/20, at 1:21 p.m. NA-F ough at meals, she was ot have dentures in. NA-F s coughing like that, they rse to assess if no nurse was					
	stated she normally today got a regular grilling them. R10 s dentures, but forgot have to remind her	on 9/25/20, at 1:34 p.m. R10 / gets a ground burger, but whole burger as they were stated she normally wore her t them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H as ok.					
	stated resident's die wished for an upgra	on 9/25/20, at 3:06 p.m. RN-B ets could be upgraded if they ade, but would have to sign a s statement. R10 did not have					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
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F 689	a risk versus benefi she given the risks a regular hamburge When interviewed of Cook-A stated they who had signed a ri for a diet upgrade, it they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Gr consistency and pa pureed food if desir When interviewed of registered dietician coughing during a ri the DON, food servi therapy. This had ri facility should not pi diet without risks be and a form signed. When interviewed of DON and RN-A stat the correct diet text swallowing problem if a resident is coug	its statement signed nor was of choking when provided with er today. on 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the s ordered and not a regular ion Form provided by Cook-A had been completed by d indicated R10 was to have a ound Meat NDD2 diet tient could downgrade to red. on 9/28/20, at 10:21 p.m. the (RD) stated if a resident were neal it should be reported to ice director and speech not been done for R10. The rovide an upgraded texture eing explained to the resident on 9/28/20, at 2:37 p.m. the ted it is important to provide ure for residents with ns. A nurse should be notified	F	589			

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
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F 689	swallowing medicat period. The MDS fu oversite, set up whe altered textures. R5's Speech Thera indicated diagnoses and oral phase dysp indicated R5 had m the evaluation had f dentures that did no without dentures, R consistency solids a Advanced. R5 was of materials into the penetration (passag and/or asphyxiation R5's Care Assessm dated 1/20/20, indic mechanically altere completed, but was planning. R5's care plan date risk for nutritional al pain front thorax an diet. Staff were dire and report to physic dysphagia when ea R5's Nutritional Eva a diet order for NDE	ing during meals or when tions during the assessment arther indicated supervision, en eating and mechanically py Evaluation dated 1/25/19, s of cerebral infarction (stroke) phagia. The evaluation further issing teeth, and at the time of full upper and partial lower of fit. The evaluation indicated to could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx,) h. ment Area Worksheet (CAA) cated R5 required a d diet. There was no analysis a noted to proceed to care and 3/20/20, indicated R5 was at literation related to chronic ad diet restriction for NDD3 acted to monitor, document cian for signs or symptoms of	F 6	89	DEFICIENCY)		

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245090	B. WING	i			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	R5's Care guide for and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticke Dysphagia Advance further directed to p hamburger on bun, vegetables, backed lettuce, soft ice crea During an observat R5 sat alone at a ta while she ate her m whole hamburger w covered the burger There were various area including nurs stopped to see why p.m. R5 was observ for someone get an having a seizure. S' of the dining room. When interviewed of stated R5 should have beans, potato salad should not have have have been ground a potato chips or who When interviewed of stated she has occa "spells," and has no When interviewed of Cook-A stated the f	 staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, d care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw d beans, no bacon, shredded am and milk. ion on 9/25/20, at 12:50 p.m. able and was noted to cough heal. R5's plate contained a with a wedge of lettuce that on a bun and potato chips. is staff throughout the dining ing and dietary, but no one R5 was coughing. At 12:52 wed to be shaking and asked nurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A ave received ground meat, d, soft cooked vegetables. R5 d a bun, the burger should and should not have received ble leaf lettuce. on 9/25/20, at 1:10 p.m. R5 asional seizure that are like, 	F	689			

If continuation sheet Page 33 of 61

		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING	;			C 28/2020
NAME OF	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	have ground meat, For the noon meal mechanical texture ground hamburger, was the cook's resp resident is getting the When interviewed of stated staff should coughing and shou have received the of who gave her the w When interviewed of Dietary Aide-A repo- aides deliver meal the When interviewed of stated a resident is upgraded texture if been signed. The re- order from the physic and benefit form. R On 9/25/20 at 3:08 should have received not, the Cook is resp correct diet. The facility Refusal and Benefits policy resident would be in benefits of necessar opportunity regardin care. The resident of times and if resider documentation sho	no bread or hard vegetables. provided on 9/25/20, a should have included, no bun, potato salad and beans. It ponsibility to make sure a he appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ld get a nurse. R5 should correct diet and did not know wrong diet. on 9/25/20, at 1:40 p.m. orted both dietary and nursing trays. on 9/25/20, at 3:06 p.m. RN-B ok to be provided an a risk and benefit form had esident should be given the sician if there is no signed risk to did not have a signed form. p.m. Cook-A- stated R5 ed the ordered diet, but did sponsible for providing the I of Care/Interventions, Risk dated 9/11, identified a nformed of the risk and ary care and given the ng their decision in the plan of would be approached 2-3 nt continued to refuse, puld be made on the Refusal of Risk and Benefits and	F	689			

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					FORM	10/13/2020 APPROVED 0938-0391
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245090	B. WING) 28/2020
PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NT MANOR LLC						
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIZ TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From pa	ge 34	F 6	389			
Dysphagia Mechan Level 1 are allowed foods may be grour no larger than one f should be easy to c Moistened ground of fish. Moist ground of with gravy or sauce pureed bread mixes and slurred breads thickness of produce products. Vegetables vegetables. Vegetable vegetables. Vegetable vegetables. Vegetable Sufficient Nursing S CFR(s): 483.35(a)(§483.35(a) Sufficient The facility must hat the appropriate com	ically Altered. All foods on I. Meats and other select and or minced into small pieces forth inch. All food items shew. Meats should be for cooked meat, poultry, or or tender meat may be served be. Breads products can be s, moistened bread crumbs that are gelled through entire at and to avoid all other bread that are gelled through entire ables should be less than 1/2 easily mashed with a fork. Staff 1)(2) Int Staff. we sufficient nursing staff with npetencies and skills sets to	F 7	725			
resident safety and practicable physical well-being of each r resident assessmer and considering the diagnoses of the fac accordance with the at §483.70(e). §483.35(a)(1) The f by sufficient numbe types of personnel of nursing care to all r resident care plans	attain or maintain the highest I, mental, and psychosocial resident, as determined by nts and individual plans of care e number, acuity and cility's resident population in e facility assessment required facility must provide services ers of each of the following on a 24-hour basis to provide esidents in accordance with :					
	RS FOR MEDICARE OF DEFICIENCIES OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER NT MANOR LLC SUMMARY STA (EACH DEFICIENCY REGULATORY OR L3 Continued From pa The National Dysph Dysphagia Mechan Level 1 are allowed foods may be grour no larger than one f should be easy to c Moistened ground of fish. Moist ground of with gravy or sauce pureed bread mixes and slurred breads thickness of produce products. Vegetables Vegetables. Vegetable vegetables. Vegetable <tr< td=""><td>IDENTIFICATION NUMBER: 245090 PROVIDER OR SUPPLIER NT MANOR LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 The National Dysphagia Diet indicated NDD2 as Dysphagia Mechanically Altered. All foods on Level 1 are allowed. Meats and other select foods may be ground or minced into small pieces no larger than one forth inch. All food items should be easy to chew. Meats should be Moistened ground or cooked meat, poultry, or fish. Moist ground or tender meat may be served with gravy or sauce. Breads products can be pureed bread mixes, moistened bread crumbs and slurred breads that are gelled through entire thickness of product and to avoid all other bread products. Vegetables should be less than 1/2 inch and should be easily mashed with a fork. Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required</td><td>RS FOR MEDICARE & MEDICAID SERVICES IOF DEFICIENCIES FCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD PROVIDER OR SUPPLIER 245090 B. WING PROVIDER OR SUPPLIER ID B. WING PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 34 F 6 Continued From page 34 F 6 The National Dysphagia Diet indicated NDD2 as Dysphagia Mechanically Altered. All foods on Level 1 are allowed. 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The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</td><td>MENT OF HEALTH AND FUMAN SERVICES Of SF OR MEDICARE & MEDICAID SERVICES Of OF DEFICIENCIES (X1) PROVIDERSUPPLIENCLAN IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING B. WING PROVIDER OR SUPPLIER ISTREET ADDRESS, CITY, STATE, ZIP CODE XT MANOR LLC ISTREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ISTREET ADDRESS, CITY, STATE, ZIP CODE ISUMMARY STATEMENT OF DEFICIENCIES PROVIDER PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFING INFORMATION) PROVIDERS PLAN OF CORRECTION CROSS-REFERENCE ACTION SHOULD CROSS-REFERENCE ACTION SHOULD CR</td><td>MENT OF HEALTH AND HUMAN SERVICES FORM. SF OR MEDICARE & MEDICAID SERVICES OMB NO. or operiodencies (x1) PROVIDERSUPPLERCIA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) Data CONDER ROVIDER OR SUPPLER 245090 B WING 09/2 ROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2/P CODE 27 BRAND AVENUE FARIBAULT, IM 55021 REQULATORY OR LC PROVDERS SUPPLER CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LC DENTFYING INFORMATION) PREFIX TAG PROVDERS TO A CORRECTION OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE (FACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 34 F 689 The National Dysphagia Diet indicated NDD2 as Dysphagia Mechanically Altered. All foods on Level 1 are allowed. Meats and other select foods may be ground or mimed into small pieces no larger than one forth inch. All food items should be eastly what should be Moistened ground or cocked meat, poultry, or fish. 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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245090	B. WING	·			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	this section, license (ii) Other nursing pe limited to nurse aide §483.35(a)(2) Exce paragraph (e) of thi designate a license nurse on each tour This REQUIREMEN by: Based on observat review, the facility fa staffing to provide fr planned needs for & R1, R3, R8, R13 an LPN-A, LPN-D, NA NA-A, RN-A, HSK-/ members (FM)-A, This had the potent residents. Findings include: R5's quarterly Minir included cognitively stroke with paralysi the body and a seiz physical assistance bathing. R5 Care Assessme 1/20/20, included, activities of daily liv and toileting. R5's care plan upda needed assistance shower/bath with or	ed nurses; and ersonnel, including but not es. ept when waived under is section, the facility must ed nurse to serve as a charge of duty. NT is not met as evidenced tion, interview and document ailed to ensure sufficient for the individualized care 8 of 8 residents (R5, R7, R4, nd R12), 12 of 15 staff (LPN-B, -D, NA-C, NA-J, NA-B, NA-F, A and NA-C) and 1 of 3 family reviewed for sufficient staffing. tial to affect all 42 current mum Data Set dated 9/4/20, / intact with diagnoses of s or weakness on one side of cure disorder. R5 required e from staff for toileting and ent Worksheet (CAA) dated R5 extensive assistance with ing (ADL) including bathing ated 8/12/20, included, R5	F	725			

Facility ID: 00568

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI COM	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	Continued From pa checks.	ge 36	F7	725			
	licensed practical n not getting the time toileting, bathing an	on 9/24/20, at 12:23 p.m. urse (LPN)-A stated, R5 was ly care she needed with id hygiene as there was not id complain about this.					
	stated, "This facility over an hour to get R5 stated it takes a the bathroom, and, Sunday and a show would rather I just to less time and effort	on 9/24/20, at 2: 20 p.m. R5 is very short staffed. I wait an answer to my call light." long time to get help to go to "I should have a bath every ver every Wednesday. The aid ake a shower because it takes . Sometime, I get neither here are not enough aids on." to R5.					
	nursing assistant (N assistance with bat she had to wait for have enough staff t	on 9/24/20, at 3:22 p.m. a NA)-D stated R5 required hing and toileting, but often assistance as they do not o get to everyone timely. ve to skip R5's bath as they n time.					
	licensed practical n complained of not g	on 9/24/20, at 3:45 p.m. a urse (LPN)-B stated, R5 getting her shower on a regular setting to her, but they were could.					
	not receive a bath of stated, "R5's showe evening due to time did not get done du	ncern Report included, R5 did or shower on 7/22/20. NA-I er did not get done on Sunday e." NA-J stated, "R5's shower e to running out of time. Her ids which [NA-I] and I were the					

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	only two on the floo had a lot to do and time to get in the ba another shower tha that we never got d Shower/bath record 2020: R5 received again until 8/17/20, 8/24//20. R5 received again until 9/21/20. Review of R5's cal p.m.) to 9/29/20 (2: the call light 166 tim wait time was over 41.5% of the time. R7's admission MD moderate cognitive of a stroke. R7 was required assistance transfer on and off R7's ADL (activities Rehab Care Assess dated 9/25/20, includecline in mobility, of bowel and bladdet toileting upon reque R7's care plan date required assistance dependent assist, of personal hygiene se occasionally inconti with toilet use."	or until 6 p.m. After 6 we still ended up not having enough ath R5 wanted. There was also it was supposed to get done one." ds dated July to September a shower on 7/19 but not and then not again until ed a bath on 9/13/20, but not I light log from 9/1/20 (6:53 24 p.m.), indicated, R5 used nes. Of the 166 instances, the 20 minutes on 69 occasions or eS dated 7/28/20, included impairment with a diagnosis a occasionally incontinent and by one staff person to of the toilet. of daily living)/Functional sment Area Worksheet (CAA) uded, R7 has had a recent was occasionally incontinent er, and needed assistance for	F 7	725			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	week she found R7 when she started he was not enough stathygiene needs in a When Interviewed of was lying in bed. R7 facility is very bad. It there seems to be r facility. Call lights cathour. I push the call bathroom and no of wet myself. I feel h chair and embarras cleaned up and chat brow was furled and R7 stated this happ When interviewed of nursing assistant (N wait for assistance her incontinent. Thi Most residents wait time to receive an a has assisted R7 aft secondary to waitin time for the call light that there have bee beginning of the shi soiled and need ass night shift is custom one licensed praction nurse (RN) for the a	IA)-C reported the previous soiled halfway up her back er shift. NA-C reported there ff to meet R7's toileting and	F	725			
	LPN-D stated there						

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG F 725	Continued From par morale among staff of this. R7's call light respon 9/22/20, at 3:51 a.m showed the call ligh the seven day period initiated, 11 (or 21.5 15 minutes to recein 14%) of these alerts to receive a respon R4's admission Min 6/29/20, included, m with diagnoses inclu- arthritis. R4 requires toileting and limited hygiene. R4 was m was occasionally in times during the as R4's incontinence C dated 7/1/20 indicat urinary incontinence assistance with toils incontinence." "She and OT [occupation the goal of returning uses incontinence period HS [night], and with R4's significant cha- included severe cos	ge 39 f and residents is low because onse time logs dated from n. to 9/28/20, 9:25 a.m. it was engaged 51 times over od. Of the 51 call light alerts 5%) of these alerts took over ve a response. Seven (or s took longer than 20 minutes se. imum Data Set (MDS) dated noderate cognitive impairment uding diabetes, dementia and ed extensive assistance with assistance with personal ot on a toileting program and continent of urine (less than 7 sessment period). Care Area Assessment (CAA) ted, "Resident triggers for e r/t [related to] need for et use and bladder e is in PT [physical therapy] nal therapy] at this time with g to the community. Resident products to aid in keeping skin e to with current toileting plan cares q [every] AM [morning], e each incontinent episode."	1	725	DEFICIENCY)	RIAIE	
	hygiene and was al	aff for toileting and personal ways incontinent of urine.					

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING	;			C 28/2020
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	 "Resident triggers f toilet use and bladd declined in both mo She has recently er life cares. Resident aid in keeping skin current toileting pla [every] AM [mornin incontinent episode R4's only Bowel an medical record was R4 was continent of R4's care plan date "Alteration with elim to, "Assist of 1 with not been updated s 8/27/20, MDS noted incontinence to tota in assistance needs hygiene. R4's nursing assist "Assist of 2 w/ Hoye ambulate." No info nursing assistants of toileting needs. During continuous of starting at 10:34 a.t if she would like to declined. No encou provided. No additio incontinence cares licensed practical in her room to check b 	for urinary incontinence r/t der incontinence. Resident has oblity and cognitive function. nrolled in hospice for end of t uses incontinence products to dry. Plan to continue to with an and complete peri cares q ig], HS [night], and with each	F	725			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING	i			C 28/2020
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASAN	IT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
	and changed R4's w When interviewed of and NA-B stated the morning cares at 7: not had time to assi- since getting her up "There are only two best, it is terrible." I we can't get to her, NA-B acknowledge without being assist When interviewed of director of nursing (should be assisted hours. The DON st needs very well. Re was present review and Bladder assess 6/24/20, noting it in bladder. RN-A revie identified R4 had no Bladder assessmer significant decline in June of 2020. RN-/ an updated assess change MDS comp explained they were R4 was on their wor should have been of changed at least ev R4's call light log fro R4 used the call light instances the wait t	A NA-B assisted R4 into bed visibly wet brief. on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or toilet of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. on 9/28/20, at 3:05 p.m. the DON) stated, she thought R4 with incontinent cares every 2 cated she did not know R4's egistered nurse (RN)-A who ved R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and of had an updated Bowel and nt, even though she had a in condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4 whecked for incontinence and very 2 hours. om 9/1/20 - 9/29/20 revealed ht 20 times. Of the 20 ime was over 10 minutes on r 40 minutes on one occasion,	F	725			

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING			C 09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 42	F7	725			
	8/20/20, included, s with diagnoses incluinjury) and dementia assistance with mose (ADL's) and did not falls with injury since had a discharge ME R1's care plan date AEB [as evidenced admission related to secondary to TBI ar disturbances." The "Resident will be sa should incident occo "Provide one on one and wheeling her do The facility provided from 7/21/20 thorou R1 had fallen in the frame. 7/14/20, 7/3 8/11/20, 8/12/20, 8/ 9/14/20 and 9/15/20 Hospital discharge s indicated R1 was tra 9/15/20 after sustain agitation. Summary fractured skull and to R1's progress notes revealed:	ed 9/2/20, included, "Fall risk by] multiple falls since o lack of safety awareness and Dementia with behavioral e goal for R1 was listed as, afe and free from serious injury ur." Staff were directed to, e care, such as taking outside own the hall." d a running list of R1's falls ugh 9/24/20, which indicated e facility 17 times in that time 81/20, 8/1/20, 8/5/20, 8/6/20, 12/20, 8/16/20, 8/16/20, 21/20, 8/29/20, 9/3/20, 0. summary dated 9/16/20, ansferred to the hospital on ning a fall related to increased a details R1 incurred a					

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING	i			C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	R1's progress note included R1 had att several times after Facility transferred started to yell out at and back. R1 repor neck and back. R1 wheelchair. Facility ratio as the facility of R1's physician was confirmed for the R hospital. R1's guard transfer situation. R1's progress note included, R1 was tr full report was given teams. The floor nu inform that R1 was safety concerns. R1's progress noted included, R1 was not marked behaviors: put herself onto the louder than her usu and 1:1, 2:2, 3:3 we remained aggressiv 911 to send R1 to e for further evaluation When interviewed of stated there were ti one attention, but th cover a unit of 30 re possible. When interviewed of	nge 43 dated 9/16/20, at 5:35 p.m. tempted to crawl out of bed returning from the hospital. R1 to her wheelchair, R1 then nd reported of pain in neck ted to facility of pain in her started to stand up from her initiated a 2 to 1 staff to R1 determined R1 was not safe. contacted and consulted and 1 to be sent back to the dian was informed of the dated, 9/16/20, at 6:24 p.m. ansferred back the hospital. A n to the police and transport arse called the hospital to returning to them due to d dated 9/16/20, at 6:28 p.m. oted to have continued swore at staff, attempted to e floor, yelling and hollering ial, R1 was extremely agitated ere attempted and R1 ve towards staff. Facility called emergency department (ED) on per physician's orders. on 9/24/20, at 1:00 p.m. NA-B mes when R1 required one on hey only had one or two staff to esidents, so this was not	F	725			

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COM	E SURVEY PLETED
		245090	B. WING	i			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa all the time and she	e fell a lot.	F 7	725			
	emergency room so would not take R1 b	on 9/24/20, at 2:56 p.m. the ocial worker stated the facility back to the facility because nough help to watch her well					
	stated R1 required time to prevent her not have the time to NA-D stated she wo	on 9/24/20, at 3:22 p.m. NA-D a significant amount of staff from falling and they just did o stay with her all the time. orked the day shift and often er shift would find R1, "sopping nent brief.					
	stated there was no	on 9/24/20, at 3:45 p.m. LPN-B ot enough staffing to supervise afe as she required individual					
	DON stated due to could not be met at	on 9/28/20, at 10:10 a.m. the limited staffing R1's needs t the facility, therefore R1 could after her last admission to the					
	8/15/20, revealed R impairment. R3 req staff physical assist diagnosis included swallowing concern mouth when eating mouth/cheeks or re	nimum data set (MDS), dated R3 had moderate cognitive juired supervision and one tance for eating. R1's a stroke. R3 had the following ns: loss of liquids/solids from or drinking, holding food in esidual food in mouth after ng during meals or when					

Facility ID: 00568

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725		-	F 7	25			
	with adequate eatin all meals in the dini	g time. The resident requires ng room r/t [related to] close eceive meals until supervision					
	stated she worked of "understaffed." NA be provided mornin especially if they re- assistance with me required individual a not eat too quickly of get enough fluid. NA	chanical lift. NA-A stated, R3 assistance for cueing him to or take too big of a bite and to A-A noted R3 often had to wait eat until they had enough staff					
	stated, R3 required make sure he ate th staff were available	on 9/24/20, at 3:22 p.m. NA-D staff to closely monitor to ne amount he should. Often no to help, he would sit and look aiting for his plate of food.					
	stated, there were s assistance in the di to figure out how to entire time due to c	on 9/24/20, at 3:45 p.m. LPN-B several residents that required ning room and it was difficult feed R3. R3 required help the hoking precautions and the entire meal time.					
	wheeled self into th wheel chair back ar	on 9/25/20, at 12:21 p.m. R3 e dining room. R3 rolled his nd forth at the table, looking al was brought to him at 12:41					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY
			A. BUILD			(C
		245090	B. WING			09/2	28/2020
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 46	F 7	725	5		
	stated there is never room to feed every	on 9/25/20, at 1:21 p.m. NA-F er enough staff in the dining one. "On a good day, we are es to assist all the residents."					
	was cognitively inta Parkinson's disease assistance of 2 staf and one person phy R8's care plan, last staff, "Alteration in o	PS, dated 8/10/20, included, R8 loct with a diagnosis of e. R8 required physical ff for transfers and supervision ysical assistance for toileting. revised 8/24/20, directed elimination r/t [related to] Assist of 1 with toileting as					
	needed for hygiene When interviewed o LPN-A stated R8 wa the morning and ne	on 9/24/20, at 12:23 p.m. as independent with cares in seded more assistance in the oted R8 might not even turn					
	stated, "We barely more independent a	on 9/24/20, at 12:56 p.m. NA-A touch base," with R8 as she is and staff need to help with ired more assistance.					
	stated there was no when she needed it with stiffness and d on her own when he	on 9/28/20, at 10:37 a.m. R8 ot enough staff to help her t. R8 stated she has problems ecreased ability to do things er Parkinson's medication was ff tell her they have a half hour					

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				_ 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	on each side of the but it is often over the they do not have en- time. R8 stated she the bathroom, she of minutes to get on o her back to hurt and unable to care for h R8's medication add dated August 2020, Carbidopa-Levodop Parkinson's disease stiffness, tremors, s control) five times of 4:00 p.m., 7:30 p.m. noted as being adm each opportunity, binot not noted. When interviewed of LPN-D stated R8 w time. LPN-D stated getting her medicat R8's call light log, d included, R13 activative two incidents, the re and 40 minutes. On time was between 4 incident, the respon- minutes. R13's quarterly MD cognitively intact wi sclerosis. R13 requires and the sclerosis. R13 requires and the sclerosis. R13 requires and the sclerosis. R13 requires and the sclerosis. R13 requires and the sclerosis. R13 requires and the sclerosis. R13	time her medication is due, hat. R8 stated staff tell her nough staff to get it to her on e does not get enough help to often has to wait 20-40 r off the toilet. This causes d she gets even more still and herself even more. ministration record (MAR), included an order for ba (a medication for treating e symptoms such as muscle spasms, and poor muscle daily; 5:55 a.m., 10:00 a.m., h. and 11:30 p.m. R8 was hinistered the medications at ut the time administered was on 9/28/20, at 10:58 a.m. ranted her medications on d R8 reported concerns with ions on time in the evening. lated 9/8/20 through 9/25/20, ated her call light 12 times. On esponse time was between 30 n two incidents the response 40 and 50 minutes. On one has time was over 100 S dated 9/18/20, included th a diagnosis of multiple uired two staff for toileting and	F 7	225			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	risk for skin breakd assistance. The ca call light in reach ar When interviewed of stated R13 was tota cares. Sometimes F breakfast as they di her up before break up, but is agreeable Often R13 would be were able to attend When interviewed of stated when coming they would find R13 often the only staff competent to use th get R13 up, and du in bed at supper tim they just didn't have her up. When interviewed of stated she is incont medical condition, s periods of time to b In addition, she ofte because there is no This was upsetting R13's call light logs reviewed. R13's cal 10 and 20 minutes 30 and 40 minutes between 40 and 50 between 50 and 60	own and required staff ire plan indicated to keep the and answer promptly. on 9/24/20, at 1:31 p.m. NA-C ally dependent on staff for R13 had to stay in bed for idn't have enough staff to get (fast. R13 would prefer to get e when they need her to be. e, "saturated" by the time they to her after breakfast. on 9/24/20, at 3:22 p.m. NA-D g on for the afternoon shift 8 soaked in urine. NA-D was on afternoons who was ne mechanical lift needed to e to this, often R13 had to stay ne. This would upset R13, but e enough help to always get on 9/28/20, at 11:05 a.m. R13 inent of urine due to her she often has to wait extended e changed in order to be dry. en is unable to get out of bed of enough staff to help her up.	F	725			

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		AND HUMAN SERVICES			FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>	IPLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245090	B. WING			C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	Continued From pa	ige 49	F 72	25		
	R12 had moderate was on hospice ser care. R12's diagnos disease, asthma/ch disease or chronic failure.	S dated 8/14/20, included, cognitive impairment. R12 rvices and required oxygen ses included coronary artery nronic obstructive pulmonary lung disease and respiratory				
	report (MAR/TAR), staff, "Connect 02.1 bedtime." and "Oxy cannula while at res marked as complet 9/17/20. The MAR/ has bipap on every cpap placement. Pl every hour overnigh completed on 9/4/2 "Bipap-Nurse must sleeping and at nigh completed the nigh On 9/24/20, at 3:45 family had concerns	nd treatment administration dated August 2020, directed 1.5 L [liters]/min [minute] at 'gen at 1.5L/min per nasal st and at night. This was not ted on the night of 9/4/20 and TAR directed "Ensure resident overnight, every night shift for lease ensure Cpap is in place nt." This was not marked as 0 and 9/17/20. and put on use daily when ht." This was not marked as t of 9/4/20 and 9/17/20.				
	residents. On 9/25/20 at 10:39 R12, (FM)-A stated through video. R12 and oxygen nasal of assist with respirato would notice times not applied, or not a amounts of time, no 3:20 a.m. to 3:50 a.	9 a.m. a family member of she monitored R12's care wore a bipap mask at night cannula during the day to bry and breathing issues. FM-A R12's bipap or oxygen was applied properly for significant bring recent example between .m.; 5:00 a.m. to 7:10 a.m., 1:17 a.m. on 9/24/20. FM-A				

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	NT MANOR LLC			27	7 BRAND AVENUE		
PLEASA				F/	ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	reported, during the the facility to alert s the interview, R12 r when she was not g needed, like she was R12 was deteriorati physically and was the oxygen. FM-A s she noted no came movement detected 11:34 p.m. and 4:09 required frequent m was on properly. FM she felt like a burde had informed the di concerns and there improvement. R12's call light log, included, R12 active Eleven of those we minutes. Six were a minutes. S	age 50 ese instances, she would call staff, without response. During noted she did not feel well getting the oxygen she as in a "daze". FM-A reported ing both cognitively and more confused when not on stated, on 9/18/20 to 9/19/20 era activity, indicating no d, in R12's room between 9 p.m. FM-A noted R12 nonitoring to ensure her bipap M-A reported R12 had told her en to staff. FM-A reported she irector of nursing of her e was no resolution or dated 9/1/20 to 9/29/20, ated the call light 66 times. re answered between 20 to 30 answered between 30 to 40 answered between 40 and 50 answered in over 60 minutes on 9/24/20, at 12:23 p.m. were not enough staff to care A explained there were e aide on west side of the care were not getting the timely care mely toileting, bathing and oad was stressful and burnout and turnover. LPN-A cussed concerns with DON and there had been no eported she helped the with cares when she was able completing treatments and	F 7	25	DEFICIENCY)		

Facility ID: 00568

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	medication pass for there was an overa getting the timely as hygiene. When interviewed of reported she was p assistant duties to h appointments and w sufficient nursing st peri-cares for reside busy with their own time baths and sho residents were not evening cares when chart a resident refu- had not been offere bathed, when they been reported to be with no changes. When interviewed of stated she worked to times when she wo building. Resident extended periods of hour. They just cou- meal times resident "Short staffing is a of been reported to the there was nothing to When interviewed of stated there was or residents. Nurses of addition to their reg- were not able to mat-	ge 51 r residents. LPN-A reported II concern with resident not ssistance with bathing and on 9/24/20, at 1:31 p.m. NA-C ulled away from her nursing help with electronic medical wound rounds. There was not aff to provide oral care and ents. The nurses were too duties to assist. Most of the wers were missed and assisted with morning and in they preferred. Staff would used a bath, when the resident ed, or chart a resident was were not bathed. This had oth the DON and administrator on 9/24/20, at 3:22 p.m. NA-D the night shift and there were uld be the only nurse aid in the call lights were on for f time- sometimes over an uld not get to them timely. At ts complain of cold food. daily occurrence." This had e administrator but was told hey could do about it. on 9/24/20, at 3:45 p.m. LPN-B he or two aides for 30 were expected to provide 5 residents each shift in ular duties. Sometimes, they ake sure resident treatments /hen staff come from a	F	725			

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245090	B. WING _			(09/2	28/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 550	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPP EFICIENCY)	BE	(X5) COMPLETION DATE
F 725	they do not have er their work. LPN-B I management and w When interviewed of HSK-A stated nursi "burned out," becau time to meet reside When interviewed of administrator, assis RN-A were interview facility assessment staffing needs to m needs. Typically, th assistant per 10 res were residents who wait times, particula "The staff have may noticed "a lot of sta administrator noted dynamics and cultu staffing concerns. T was committed to in and chipping in with she felt there was too many staff and reported there was census was down. The facility staffing staff, "Our facility pi staff with the skills a provide care ad ser accordance with res	ey are reluctant to return as nough time to complete all of had reported this concern to vas told they had enough staff. on 9/25/20, at 11:12 p.m. ng assistance seem to be, use they do not have enough nt needs. on 9/28/20, at 3:36 p.m. the stant administrator, DON and wed together. There was no to determine the specific eet resident care planned here should be 1 nursing sidents. DON stated there o complained about call light arly at night time. RN-A stated, de it seem so drastic" but	F 72				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245090	B. WING		09	C / 28/2020
NAME OF I	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CC		120/2020
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 725		ect care staff are determined residents based on each	F 725	5		
F 805 SS=D	Food in Form to Me CFR(s): 483.60(d)(eet Individual Needs 3)	F 805	5		
	§483.60(d) Food ai Each resident rece	nd drink ives and the facility provides-				
	to meet individual r This REQUIREMED by: Based on observa review, the facility f accordance with re	NT is not met as evidenced tion, interview, and document failed to prepare food in sidents needs for 2 of 3 R10) reviewed who required				
	Findings include:					
	cognitively intact w	S dated 7/14/20, included ith diagnoses of diabetes and required supervision and set eating.				
	included a diagnos dysphagia (difficult throat) and oral pha in the mouth). The risk for aspiration of Recommendations consistency, small (chewing), swallow	were made for puree bites thorough mastication bites before taking another g, single sips, alternate				

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE COMF	E SURVEY PLETED
		245090	B. WING _			09/2) 28/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Æ		
PLEASA	NT MANOR LLC			27 BRAND AVENUE FARIBAULT, MN 55021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD E	BE	(X5) COMPLETION DATE
TAG F 805	Continued From pa R10 would be appro R10's nutritional sta identified a risk fact diet. No analysis of completed. R10's care plan dat nutritional alteration meals; had diet ress [National Dysphagia ground or are minor pieces, they are mo and could have req directed to monitor, physician as neede swallowing problem R10's undated nurs included mechanica R10's Nutrition Eva identified a mechan meat. Speech ther all meats ground, u for preference." R10's Oral/Dental E indicated R10 had f During observation was observed to be 12:47 p.m. it was no hamburger patty on	age 54 opriate for diet upgrade. atus CAA dated 4/10/20, tor of a mechanically altered f this risk factor was ted 4/1/20, included, risk for n related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be ed no larger than 1/4 inch bist, with some cohesion] diet juested puree. Staff were , document, and report to the ed for signs and symptoms of	F 80	DEFICIENCY)	PROPRI	IATE	DATE
	as the staff had gril desired one. R10 c	ad requested the regular patty led out the burgers and she continued to cough while cked to see if she was alright,					

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 805	Continued From pa	-	F٤	305			
	nor did anyone brin	g her dentures.					
	texture and to provi	ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded					
	aide (DA)-A stated mechanical soft die	on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating.					
	(CK)-A stated, a me ground meat, no br	on 9/25/20, at 1:12 p.m. cook echanical soft diet should have ead or hard vegetables. The responsible to ensure the ed.					
	stated R10 does co unaware R10 did no stated if someone is	on 9/25/20, at 1:21 p.m. NA-F ough at meals, she was ot have dentures in. NA-F s coughing like that, they se to assess if no nurse was					
	stated she normally today got a regular grilling them. R10 s dentures, but forgot have to remind her	on 9/25/20, at 1:34 p.m. R10 / gets a ground burger, but whole burger as they were stated she normally wore her t them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H as ok.					
	stated resident's die wished for an upgra	on 9/25/20, at 3:06 p.m. RN-B ets could be upgraded if they ade, but would have to sign a s statement. R10 did not have					

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 805	a risk versus benefi she given the risks a regular hamburge When interviewed of Cook-A stated they who had signed a ri for a diet upgrade, it they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Gr consistency and pa pureed food if desir When interviewed of registered dietician coughing during a ri the DON, food servi therapy. This had ri facility should not pi diet without risks be and a form signed. When interviewed of DON and RN-A stat the correct diet text swallowing problem if a resident is coug	its statement signed nor was of choking when provided with er today. on 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the s ordered and not a regular ion Form provided by Cook-A had been completed by d indicated R10 was to have a round Meat NDD2 diet tient could downgrade to red. on 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to vice director and speech not been done for R10. The rovide an upgraded texture eing explained to the resident on 9/28/20, at 2:37 p.m. the ted it is important to provide ture for residents with ns. A nurse should be notified	F	805			

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	Continued From par coughing and choki swallowing medicat period. The MDS fu oversite, set up whe altered textures. R5's Speech Thera indicated diagnoses and oral phase dysp indicated R5 had m the evaluation had f dentures that did no without dentures, R consistency solids a Advanced. R5 was of materials into the penetration (passag and/or asphyxiation R5's Care Assessm dated 1/20/20, indic mechanically altered completed, but was planning. R5's care plan date risk for nutritional al pain front thorax an diet. Staff were dire	ge 57 ing during meals or when tions during the assessment urther indicated supervision, en eating and mechanically py Evaluation dated 1/25/19, s of cerebral infarction (stroke) phagia. The evaluation further issing teeth, and at the time of full upper and partial lower of fit. The evaluation indicated 55 could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx,) the ment Area Worksheet (CAA) cated R5 required a d diet. There was no analysis a noted to proceed to care and 3/20/20, indicated R5 was at literation related to chronic and diet restriction for NDD3 acted to monitor, document cian for signs or symptoms of			CROSS-REFERENCED TO THE APPROP		
	diet was changed to R5's Nutritional Eva a diet order for NDE	dated, 1/25/19, indicated her o NDD3 by Speech therapy. aluation dated 9/4/20, identified D3, Dysphagia Advanced diet					
	level 3.						

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		AND HUMAN SERVICES				FORM	10/13/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245090	B. WING				C 28/2020
NAME OF I	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASA	NT MANOR LLC				27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 805	R5's Care guide for and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticke Dysphagia Advance further directed to p hamburger on bun, vegetables, backed lettuce, soft ice crea During an observat R5 sat alone at a ta while she ate her m whole hamburger w covered the burger There were various area including nurs stopped to see why p.m. R5 was observ for someone get an having a seizure. S' of the dining room. When interviewed of stated R5 should have beans, potato salad should not have have have been ground a potato chips or who When interviewed of stated she has occa "spells," and has no When interviewed of Cook-A stated the f	 staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, d care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw beans, no bacon, shredded am and milk. ion on 9/25/20, at 12:50 p.m. able and was noted to cough neal. R5's plate contained a <i>v</i>ith a wedge of lettuce that on a bun and potato chips. staff throughout the dining ing and dietary, but no one R5 was coughing. At 12:52 wed to be shaking and asked nurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A ave received ground meat, d, soft cooked vegetables. R5 d a bun, the burger should and should not have received ple leaf lettuce. on 9/25/20, at 1:10 p.m. R5 asional seizure that are like, 	F 8	305			

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	FORM	10/13/2020 APPROVED 0938-0391					
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUC A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245		245090	B. WING			C 09/28/2020	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PLEASANT MANOR LLC					7 BRAND AVENUE ARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 805	have ground meat, For the noon meal mechanical texture ground hamburger, was the cook's resp resident is getting the When interviewed of stated staff should coughing and shoul have received the of who gave her the w When interviewed of Dietary Aide-A repo- aides deliver meal the When interviewed of stated a resident is upgraded texture if been signed. The re- order from the physic and benefit form. R On 9/25/20 at 3:08 should have received not, the Cook is resp correct diet. The facility Refusal and Benefits policy resident would be in benefits of necessar opportunity regardin care. The resident w times and if resider	no bread or hard vegetables. provided on 9/25/20, a should have included, no bun, potato salad and beans. It consibility to make sure a he appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ld get a nurse. R5 should correct diet and did not know vrong diet. on 9/25/20, at 1:40 p.m. orted both dietary and nursing trays. on 9/25/20, at 3:06 p.m. RN-B ok to be provided an a risk and benefit form had esident should be given the sician if there is no signed risk t5 did not have a signed form. p.m. Cook-A- stated R5 ed the ordered diet, but did sponsible for providing the of Care/Interventions, Risk dated 9/11, identified a nformed of the risk and ary care and given the ng their decision in the plan of would be approached 2-3 nt continued to refuse, uld be made on the Refusal of Risk and Benefits and	F 8	05			

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DEPART CENTE	RINTED: 10/13/2020 FORM APPROVED MB NO. 0938-0391						
CENTERS FOR MEDICARE 8 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUC A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245090	B. WING	i			C 28/2020
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PLEASANT MANOR LLC					27 BRAND AVENUE FARIBAULT, MN 55021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 805	F 805 Continued From page 60			805			
	Continued From page 60 The National Dysphagia Diet indicated NDD2 as Dysphagia Mechanically Altered. All foods on Level 1 are allowed. Meats and other select foods may be ground or minced into small pieces no larger than one forth inch. All food items should be easy to chew. Meats should be Moistened ground or cooked meat, poultry, or fish. Moist ground or tender meat may be served with gravy or sauce. Breads products can be pureed bread mixes, moistened bread crumbs and slurred breads that are gelled through entire thickness of product and to avoid all other bread products. Vegetables should be less than 1/2 inch and should be easily mashed with a fork.						

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