DEPARTMENT OF HEALTH

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,

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

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 new admissions.

This Department is also recommending that CMS impose:

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

- 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)

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:

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

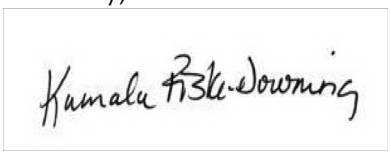
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/24/20, 9/25/20 and 9/28/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5090056C at F689 H5090057C at F677 and F725 H5090059C at F677, F686 and F725 The following complaints were found to be unsubstantiated: H5090055C and H5090058C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		11/2/20

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

Electronically Signed | 10/30/2020

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 1 resident (R7) reviewed for dignity concerns.	F 550	F550=D. Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 1 resident (R7) reviewed for dignity concerns.	

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F 550	Continued From page 2 Findings include: R7's admission Minimum Date Set (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. 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. R7's care plan dated 7/29/20, included, R7 required assistance for, "Bathing with max to dependent assist, dressing with max assist, personal hygiene set-up with minimal assist, occasionally incontinent, and requires assistance with toilet use." 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.	F 550	The residents of Pleasant Manor have the right to receive care in a dignified manner. It is the responsibility of all staff of the facility to ensure the residents' plan of care promotes their dignity and resident rights. The associated policies related to providing care in a dignified manner were reviewed and remain appropriate. R7's plan of care for toileting was reviewed and remains appropriate for currently level of function. All resident's toileting plans have been reviewed, discussed as an IDT and toileting plans appear to be appropriate at this time. IDT additionally will implement a Resident Advocate Program that will assist in promoting timely response to resident concerns. Education of executing a toileting plan of care will be completed for all nursing staff and IDT will be educated on Resident Advocate Program. Administrator/DON or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Date of completion: 11/2/2020	

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F 550	Continued From page 3	F 550		

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 and 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 state there is insufficient staff to meet the individual needs of each resident. The morale among staff and residents is low because of this. R7 being incontinent due to not being able to get to her timely is a dignity issue.

R7's call light response time logs dated from 9/22/20, at 3:51 a.m. to 9/28/20, 9:25 a.m. showed the call light was engaged 51 times over the seven day period. Of the 51 call light alerts initiated, 11 (or 21.5%) of these alerts took over 15 minutes to receive a response. Seven (or 14%) of these alerts took longer than 20 minutes to receive a response.

During a phone call interview on 9/28/20, at 3:30 p.m. the administrator stated they do not have a staffing or facility assessment in place to assist in determining staffing needs at this time. The administrator stated current staffing rations include one staff member for every ten residents. "More comradery and better communication," was needed among the staff. These measures would improve care. The administrator stated that they are working on this initiative.

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F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to issue a written bed-hold notice upon transfer to the hospital for 1 of 3 residents (R1) reviewed for hospitalizations. Findings include:	F 625	F625=D. Based on document review and interview, the facility failed to issue a written bed-hold notice upon transfer to the hospital for 1 of 3 residents (R1) reviewed for hospitalizations. Prior to transfer, it is the responsibility of the Pleasant Manor staff to offer a written	11/2/20

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F 625	Continued From page 5 R1's admission Minimum Data Set (MDS) dated 5/20/20, indicated R1 was admitted to facility on 5/14/20 with a discharge assessment-return anticipated MDS dated, 9/16/20. R1's progress note dated 9/16/20, at 6:24 p.m. included, R1 was transferred to the hospital and a full report was given to the police and transport teams. However a bed hold notice was not found in R1's medical record. When interviewed on 9/24/20, at 3:07 p.m. R1's guardian reported she had not been provided a bed hold notification and was unaware of the possibility to hold the bed for R1. When interviewed on 9/28/20, at 2:09 p.m. the interim director of nursing (DON) verified a written bed hold notice was not completed for R1. Facility policy titled, Transfer or Discharge, Emergency revised on 08/2018, indicated under bullet number 4: "The business office is responsible for: b. Informing the resident, or his or her representative (sponsor) of our facility's readmission appeal rights, bed-holding policies, ect."	F 625	bed-hold to the resident being transferred. The bed-hold policy has been reviewed and remains appropriate. All nurses and IDT members will be educated on the bed-hold policy and the steps to carry out offering a bed-hold during a transfer to the hospital. Administrator or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 11/2/2020	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide incontinence	F 677	F677=D. Based on observation, interview, and document review, the	11/2/20

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F 677	Continued From page 6 care timely, and failed to reassess continence status after a significant change for 1 of 3 residents (R3) reviewed for incontinence. Findings include: R4's admission Minimum Data Set (MDS) dated 6/29/20, included, moderate cognitive impairment with diagnoses including diabetes, dementia and arthritis. R4 required extensive assistance with toileting and limited assistance with personal hygiene. R4 was not on a toileting program and was occasionally incontinent of urine (less than 7 times during the assessment period). R4's incontinence Care Area Assessment (CAA) dated 7/1/20 indicated, "Resident triggers for urinary incontinence r/t [related to] need for assistance with toilet use and bladder incontinence." "She is in PT [physical therapy] and OT [occupational therapy] at this time with the goal of returning to the community. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode." R4's significant change MDS dated 8/27/20, included severe cognitive impairment, was totally dependent upon staff for toileting and personal hygiene and was always incontinent of urine. R4's incontinence CAA dated 8/28/20 included, "Resident triggers for urinary incontinence r/t toilet use and bladder incontinence. Resident has declined in both mobility and cognitive function. She has recently enrolled in hospice for end of life cares. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with	F 677	facility failed to provide incontinence care timely, and failed to reassess continence status after a significant change for 1 of 3 residents (R4) reviewed for incontinence. Pleasant Manor staff have the responsibility to provide care to residents who are unable to carry out activities of daily living to promote their health, including assessment during their stay and providing care daily. The associated policies related to toileting plans have been reviewed and remain appropriate. R4's toileting plan was reviewed and updated. All resident's toileting plans have been reviewed, discussed as an IDT and toileting plans appear to be appropriate at this time. Staff will be educated on executing toileting plans per plan of care. DON or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 11/2/2020	

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F 677	Continued From page 7	F 677		

current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's only Bowel and Bladder assessment in the medical record was dated 6/24/20, and indicated R4 was continent of bowel and bladder.

R4's care plan dated 6/26/20, included, "Alteration with elimination." Staff were directed to, "Assist of 1 with toileting." The care plan had not been updated since 6/26/20, even though the 8/27/20, MDS noted a decline in urinary incontinence to totally incontinent and an increase in assistance needs for toileting and personal hygiene.

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.

During continuous observation on 9/25/20, starting at 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to provide incontinence cares occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. LPN-D then brought R4 to the dining room. Incontinence cares were not provided. At 1:58 p.m. NA-F and NA-B assisted R4 into bed and changed R4's visibly wet brief.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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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. 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, 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."	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		11/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 9 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide repositioning timely for 1 of 3 residents (R4) reviewed who were at risk of developing pressure ulcers. Findings include: R4's significant change Minimum Data Set (MDS) dated 8/27/20, included severe cognitive impairment with a diagnosis of dementia. R4 required extensive assist for bed mobility and total staff assistance for transfer. R4 was at risk for pressure ulcer development, but did not have a current pressure ulcer. R4's pressure ulcer Care Area Assessment (CAA) dated 8/28/20 included, "Resident triggers for pressure r/t [related to] need for assistance with bed mobility and bowel and bladder incontinence. Resident is at risk for skin break down r/t cognitive impairment, dx [diagnosis] of HTN [hypertension] and Type 2 DM [diabetes]	F 686	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 residents 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's repositioning plan of care was reviewed and remains appropriate. R4's skin has been reviewed and remains free of skin alterations. All resident's repositioning plans of care have been reviewed, discussed at IDT, and repositioning plans of care remain appropriate. All nursing staff will be educated on the	

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F 686	Continued From page 10 and daily use of ASA [aspirin] and Coumadin [blood thinner]. She is incontinent of bowel and bladder. Resident noted to have scabbed area over skin tear on LLE [lower left extremity]. Skin otherwise intact. Preventative skin measures in place with toileting and repositioning q [every] 2 hours, pressure redistribution cushion to wheelchair and mattress to bed, routine skin cares q [every] AM [morning] and HS [night], and weekly skin inspections." R4's care plan dated 6/26/20 included, "Potential alteration in skin integrity." Staff were directed to, "Monitor skin integrity daily. Weekly skin inspection by nurse. Treatment to open areas per order. Pressure redistribution mattress to bed. Pressure redistribution cushion to wheelchair, chair." Care plan interventions updated 9/1/20. R4's care plan further indicated, "Alteration in mobility related to end of life" with interventions: "Dependent with bed mobility: A1-2 [assist of 1-2 staff]. Maxi lift (Hoyer) [mechanical lift] with transfers. Turn and reposition Q2H [every 2 hours]." Additionally R4's care plan specified, "Alteration in comfort," with an intervention dated 9/8/20: "Position q2hrs [every 2 hours] and PRN [as needed] with pillows for comfort." R4's nursing assistant Care Sheet included, "Assist of 2 w/ [with] Hoyer [mechanical lift]; does not ambulate." The care sheet did not direct staff on how often to assist R4 with turning and repositioning. A Hospice Facility Visit progress note dated 9/3/20 included, "Does verbalize some discomfort to bottom." During continuous observation on 9/25/20,	F 686	repositioning policy. DON or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 11/2/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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F 686	Continued From page 11	F 686		

starting at 10:25 a.m. R4 was attempting to adjust herself in the wheelchair, but was not able to effectively adjust herself. At 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. The 2 staff members offered to recline R4's wheelchair. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to reposition occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining room. At 1:55 p.m. nursing assistant (NA)-F and 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 terrible 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.

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 staff for repositioning." The policy further instructs,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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F 686	Continued From page 12 "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."	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 3 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 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: R1's quarterly Minimum Data Set (MDS) dated 8/20/20, included, severe cognitive impairment with diagnoses including TBI (traumatic brain injury) and dementia. R1 required extensive	F 689	F689=G. Based on observation, interview, and document review, the facility failed to comprehensively assess 3 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 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. Pleasant Manor ensures that the residents' environments remain safe and as free of accident hazards as possible. The facility identifies each resident at risk for accidents and develops a plan of care	10/1/20

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	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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F 689	Continued From page 13 assistance with most activities of daily living (ADL's) and did not ambulate. R4 had 2 or more falls with injury since the prior assessment. R1 had a discharge MDS dated 9/16/20. R1's falls Care Area Assessment dated 5/22/20, included, "Resident triggers for falls r/t [related to] having impaired balance and daily psychotropic medication use. Resident has decreased mobility following hospitalization for a UTI [urinary tract infection] and increased behaviors. Resident was involved in a MVA [motor vehicle accident] last November and suffered multiple major injuries including but not limited to: skull fractures, TBI, rib fractures, and wrist fractures." "Resident is at increased risk for falls r/t cognitive impairment, agitation, and daily use of psychotropic, anticonvulsant, antihypertensive, and benzodiazepine medications. She is incontinent of bowel and bladder. She does not have a history of falls prior to admission and has not had any falls since admission. Resident was moved to a room closer to the nurses station for safety. Plan to continue to monitor for safety, keep call light in reach, and follow therapy recommendations." The CAA indicated falls would be addressed in the care plan. R1's admission Fall Review Evaluation dated 5/19/20, included a check list of risk factors for falls as identified in the 5/22/20 CAA. However, there was no analysis of fall risk factors or identification of interventions that may mitigate or reduce the chance of R1 falling. R1's care plan dated 9/2/20, included, "Fall risk AEB [as evidenced by] multiple falls since admission related to lack of safety awareness secondary to TBI and Dementia with behavioral	F 689	addressing safety issues and implements procedures to prevent accidents and incidents. The policy related to assessment of falls have been reviewed and remain appropriate. The policy related to modified textured diets has been reviewed and remain appropriate. R4 and R3's incidents have been reviewed, assessed, and plan of care updated. R1 has been discharged from the facility. All resident's incidents have been reviewed, assessed, and plan of care updated appropriately. All resident's diet textures plans of care have been reviewed and remain appropriate. Nurses were educated on post fall evaluation process and IDT was educated on the process of incident review and analysis and expectations regarding timely completion. Culinary staff were educated on proper service of modified textured diets Administrator/DON or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 10/1/2020	

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	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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F 689	Continued From page 14	F 689		

disturbances." The goal for R1 was listed as, "Resident will be safe and free from serious injury should incident occur." Staff were directed to, use one assist for transfers with a standing lift. Place bed on low position. Have fall mats on both sides of bed. Leave door open at all times unless providing cares. Use a tilt-in-space wheel chair for comfort. To be visually supervised when in wheel chair. Provide one on one care, such as taking outside and wheeling her down the hall.

R1's Action Summary dated 7/1/20 to 9/28/20, identified R1 had fallen 17 times on 7/14/20, 7/31/20, 8/1/20, 8/5/20, 8/6/20, 8/11/20, 8/12/20, 8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20, 8/21/20, 8/29/20, 9/3/20, 9/14/20 and 9/15/20. In addition, R1's progress notes dated 7/29/20 and 8/30/20 identified she had fallen, but these were not included on the Action Summary. There were no progress notes or incident reports for the falls identified on the Action Summary which were dated 8/11/20, 8/12/20 (2 falls), 8/19/20, or 9/14/20. Twelve of the falls were identified in the progress notes as being a fall from bed onto the mat next to the bed. These were on 7/31/20, 8/5/20, 8/6/20, 8/16/20 - three times, 8/21/20- 3 times, 8/29/20, 8/30/20, and 9/3/20. 2 falls were identified from a wheel chair on 8/29/20 and 9/15/20. 1 fall from recliner on 7/29/20. There was no documentation to determine the circumstances of the falls that occurred on 7/14/20, 8/11/12, 8/11/20, 8/12/20, 8/19/20 or 9/14/20.

R1's Incident Review and Analysis dated 7/20/20, included, R1 was found on the floor on 7/14/20. Incident Analysis included, "Staff was walking by resident's room and saw resident lying on the floor." "Resident with lack of safety awareness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 15	F 689		

which contributes to resident's fall risks due to diagnosis of unspecified TBI w/o loss of consciousness; Dementia with behavioral disturbance." The follow-up/intervention section listed: proper footwear, evaluation by PT/OT (physical therapy/occupational therapy), bed in lowest position and soft touch call light. Resident to be visually supervised when in wheelchair. Provide tilt-in-space wheelchair with the ability to recline resident when in chair to provide ore comfort. Staff providing 1:1 (one on one) care such as taking her outside and wheeling her down the hall. "Resident with behaviors and often times heard yelling. Resident requires 1:1 attention to staff and to redirect and provide reassurance. Resident is at high fall risk due to lack of safety awareness due to TBI and dementia. Resident also experiences agitation and restlessness and could be the reason of resident's self transferring to get staff's attention to tend to her." These interventions were added to the care plan.

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."

R1's progress note dated 7/31/20, included, "At 8:40 PM writer heard resident calling out from her room and found resident on the floor laying next to her bed." Abrasions were noted to both knees. There was no assessment of this fall. Interventions added were, "All staff will make sure resident's bedroom door is not closed completely and will keep bathroom light on when room is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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F 689	Continued From page 16	F 689		

dark." Keeping the bathroom light on when the room is dark was not added to the care plan.

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 had knees on ground and torso was still in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 17	F 689		

bed. Resident was confused and wanted to leave facility."

R1's progress note dated 8/16/20, at 10:35 p.m. included, "Aid called nurse in to find resident sitting on floor with arms on the bed. Resident was wanting to leave facility."

R1's progress note dated 8/16/20, at 10:40 p.m. included, "Resident was on floor sliding off her bed. Resident had just fallen previous to this but slid out of her bed. Resident was waning [sic] to leave facility and calling out to staff "someone get me out of here."

R1's progress note dated 8/21/20, included, "Writer observed resident sitting on floor x 3 on mat next to bed this shift. No injuries noted. Bed at lowest position. Asked resident what happened and resident stated, "Trying to get out of here."

R1's progress note dated 8/29/20, included, "At 2:15 PM writer heard resident yelling from lobby. Writer found resident laying on the floor next to her W/C [wheel chair] yelling "Ow my head." Writer found 1" [inch] x 1.5" abrasion to resident's forehead. Resident was wearing appropriate footwear, foot pedals in place on W/C, and no incontinence noted. Resident unable to describe to writer what happened except that "I fell and hit my head." Cool wet towel was applied to forehead. Then found an abrasion on her knee also.

R1's progress note dated 8/30/20, included, "Writer heard repeated yelling out from resident's room and found resident on the floor next to her bed. Bed was in lowest position, call light within

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F 689	Continued From page 18	F 689		

reach, fall mats in place both sides of bed, and resident not incontinent."

R1's progress note dated 8/30/20, noted a bruise on right index finger and a scrape on her head. There was no incident report or assessment to determine when these injuries occurred.

R1's progress note dated 8/31/20, included, the physician had been updated on bruise to right index finger.

R1's progress note dated 9/2/20, included, "Ice to sore right finger."

R1's treatment record identified staff were to monitor right index finger related to a fall. However, it did not identify which fall caused this injury.

R1's progress note dated 9/3/20, included, "Writer heard resident yelling from her room and when writer arrived resident was sitting on the floor next to her bed yelling, "Help me get back up. Bed was in lowest position with fall mats in place and call light in reach."

Even though R1 had fallen from bed 13 times, there was no comprehensive assessment to determine the reason R1 was falling from bed, any pattern in time of day or situation, or to determine why the current interventions were not working to prevent further falls.

R1's progress note dated 9/10/20, included, "Monitor right index finger related to a fall." "Nail bed and part of finger appears black."

R1's progress note dated 9//13/20, identified to,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

"Monitor right index finger related to a fall." "Patients finger continues to be black around the nail bed no redness or warmth noted to site. Nail remains intact at this time."

R1's Incident Review and Analysis report dated 9/15/20, identified R1 had fallen from her wheelchair on 9/15/20. No assessment of the cause of R1's fall from the chair was completed. The form identified R1 was sent to the emergency room for evaluation due to a head wound.

R1's hospital Admission History and Physical dated 9/15/20, included, "Patient was found on floor in bedroom and then seemed to throw herself on floor at nursing station. She has been agitated/verbally upset at times. Wanting to go upstairs." The results from a CT of head noted an acute nondisplaced fracture of the left posterial parietal bone (skull fracture). R1's hospital discharge summary identified R1 had sustained a closed skull fracture and a fracture of her right hand 2nd finger which would be splinted before returning to the nursing home. The finger fracture was in a stage of healing, identifying it had happened in the past. The facility identified an injury to R1's right index finger in the the progress notes on 8/30/20. However, this was not assessed by a physician or x-rayed until hospitalized on 9/15/20.

When interviewed on 9/24/20, at 1:00 p.m. NA-B stated R1 had fallen from bed a lot and from her wheel chair, she was constantly trying to stand up and required one on one attention or she would fall. NA-B stated they did not have time to do one on ones with R1. NA-B did not know of any interventions that helped R1 with the agitation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

and trying to stand up all the time, other than to sit with her one on one, winch was not possible as other residents required care too.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated R1 had fallen frequently, she would scream and throw herself from bed. The only interventions she knew of was to have the bed in the low position and mats on the floor so when R1 did this she wouldn't be injured. NA-C remembered R1 had a large swollen egg sized area on her forehead and had broken her finger, but did not know when this occurred.

When interviewed on 9/24/20, at 3:07 p.m. R1's guardian stated they were concerned about R1 sustaining a fractured finger that went undiagnosed for so long.

When interviewed on 9/24/20, at 3:45 p.m. licensed practical nurse (LPN)-B stated R1 was constantly throwing herself off the bed and threatening to throw herself off the bed. There was not enough staff to do one on ones and supervision with R1. LPN-A was unable to find any assessment of R1's falls for pattern or to determine why she was falling. LPN-A stated it was R1's behaviors, but was unable to find any assessment of R1's behaviors to determine why she was, "throwing herself," out of bed.

When interviewed on 9/28/20, at 10:10 a.m. the director of nursing (DON) stated they did not have a good system for when someone falls and they are trying to improve this process. The nurse should fill out an Incident Review and Analysis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

after each fall. The DON was only able to find 4 of these for R1's falls, which were for the falls sustained on 7/14/20, 7/31/20, 8/1/20, and 9/15/20. The DON did not know why this assessment had not been filled out for any of the other falls R1 sustained. R1 had behavioral issues and really required one on one attention, which they were unable to provided. The DON was unable to provide any assessment to determine if there was a pattern to R1's falls, and what interventions may assist R1 with her anxiety/behaviors that led to her falling so frequently. No assessment had been completed of R1's behaviors to determine interventions that may help.

R4's significant change MDS dated 8/27/20, included severe cognitive impairment with a diagnosis of dementia with behavioral disturbance. R4 required extensive assist for bed mobility and dressing and total staff assistance for transfer, toileting, and personal hygiene. R4 was totally incontinent of bladder and rejected cares 1-3 times during the assessment period. R3 had 1 fall without injury since prior assessment.

R4's fall CAA included, "Resident triggers for falls r/t having impaired balance, history of falls, and psychotropic medication use. Resident has declined in both mobility and cognitive functions. She has recently enrolled in hospice for end of life cares. Has increased risk of falls r/t daily use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

of hypoglycemic, antihypertensive, diuretic, narcotic, and psychotropic medications. She is incontinent of bowel and bladder. She has had a recent fall from bed. Plan to continue to monitor for safety and keep call light within reach."

R4's care plan dated 6/26/20 indicated, "Fall risk related to [blank]. Staff were directed, "Bed in lowest position. Call light within reach; fall mat. Follow PT and OT instruction for mobility function." The most recent intervention, "Ambulate to dining room with FWW [front wheel walker] support with CGA [contact guard assist] 120 ft [feet] x1 [with 1 staff] with FWW support" was added 7/22/20. No additional updates had been made.

R4's nursing assistant Care Sheet included, "Assist of 2 w/ [with] Hoyer [mechanical lift]; Does not ambulate; fall mat; call light within reach."

R4's progress note dated 8/26/20, at 10:51 p.m. included, "At 7:35 pm nurse aide found resident lying on floor next to bed. Resident appeared agitated/anxious and continued to try and stand/yell at staff. Resident swinging arms at staff when trying to position Hoyer [mechanical lift] sling so resident assisted back up into bed with Ax2 [assist of 2 staff]. Call light was within reach; fall mat was in place next to bed; bed was in lowest position; room was clear of clutter and well lit." "Resident received PRN [as needed] Seroquel [antipsychotic] for increased agitation/anxiety and was asleep within the following hour. Hospice, ADON [assistant director of nursing], and emergency contact were all notified. Writer and emergency contact talked about in-facility family visits in hospices [sic] to ease resident's anxiety/agitation and emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23	F 689		

contact thought it would be worth a try; Emergency contact is going to try and stop for a visit tomorrow."

When interviewed on 9/28/20, at 10:00 a.m. registered nurse (RN)-A stated there was no incident report or post fall follow-up report on R4's fall. R4's care plan was incorrect about walking R4, as she is no longer able to ambulate.

When interviewed on 9/28/20, at 11:35 a.m. family member (FM)-B stated they had not been allowed to visit related to COVID and was concerned about R4's falls. FM-B stated R4 would not be able to see them out her window for a visit. No one had spoken to them about possibly visiting to decrease anxiety.

When interviewed on 9/28/20, at 12:35 p.m. LPN-D stated R4 had fallen a couple times, rolling from bed. They put a mat on the floor next to the bed and make sure R4 has her call light in reach. LPN-D stated R4 would not know how to use the call light and was unsure why that was an intervention.

When interviewed on 9/28/20, at 3:05 p.m. RN-A stated, R4 was to have increased family window visits after this fall to aide in preventing more falls. The DON stated, the interdisciplinary team should meet after each fall, update care sheets and care plan, and communicate the change, but the increased family visits had not been communicated to the family or added to R4's care plan. The facility was behind in updating care plans.

R3's admission MDS dated 8/15/20, included moderate cognitive impairment with diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 risk 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25	F 689		

and free from falls." Staff were directed to, Answer call light promptly, use a mechanical lift for transfers, follow therapy instructions, call light in reach, proper footwear, ensue frequently used items were in reach.

R3's progress note dated 8/10/20, at 9:31 p.m. included, "Writer was called into room when aid walked in and saw resident laying prone on the floor. Resident was next to wheelchair and was eating supper. Aid, ADON and writer helped resident up using hoyer [mechanical] lift. Resident states that he was eating and his spoon dropped and he went to go catch it and fell out of his wheelchair. Resident states he hit his nose on the chair that was next to the wheel chair."

R3's progress note dated 8/22/20, at 6:55 p.m. included, "Residents door was open and writer was at the medicine cart adjacent to the room." "Pt [patient] was attempting at self transfers and RN heard some sound that was apparently from his wheel chair and no sooner than he turned, he saw the resident fall to the floor."

R3's progress note dated 8/28/20, included, "Writer was called by aid to assist resident off the floor. Resident was on the ground on his bottom and had his hands holding onto side rail of bed. Resident was sitting crossed legged next to bed sitting up. Resident states he was getting out of his wheel chair to get into bed. Resident then slipped off the bed and onto his bottom next to bed. Resident's vital signs were within normal limits. Resident was reminded to use his call light for all transfers."

R3's progress note dated 9/4/20, 10:32 p.m. included, R3 self transferred and was found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26 sliding off edge of bed. R3's progress note dated 9/11/20, included, "Resident was laying on back on the ground. Resident was holding handle gripper in hand and waiving it in the air. Residents wheelchair was right next to him with the breaks unlocked. Resident states he was chasing the cats out of his room and using the handle gripper to get them out of his way. Resident then fell out of wheelchair while doing this." "Resident was told there were no cats in this facility." There was no assessment of R3's belief there were cats in his room, even though R3 had not had hallucinations or delusions at the time of the comprehensive assessment. When interviewed on 9/28/20, at 10:31 a.m. LPN-C stated other than what was already in the care plan, no new interventions were added after any of these falls. LPN-C was unable to provide any post fall assessment for any of these falls. The facility had not assessed each fall to determine root cause, nor place interventions to prevent the falls from happening again. R3 had increased confusion after admission, which was not assessed other than to offer psych services, which the family declined. Normally, the interdisciplinary team would assess each fall the next day and place new interventions based upon that assessment, but this had not been done for R3. When interviewed on 9/28/20, at 11:44 a.m. the 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	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27	F 689		

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 prevent serious injury from falls. 6. Care plans will be updated to reflect fall interventions."

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.

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 consistency, small bites thorough mastication (chewing), swallow bites before taking another bite/sip, slow pacing, single sips, alternate between liquids/solids. The report indicated further analysis would be required to determine if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28	F 689		

R10 would be appropriate 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.

R10's care plan dated 4/1/20, included, risk for nutritional alteration related to coughing during meals; had diet restrictions which included NDD2 [National Dysphagia Diet, level 2- meats are to be ground or are minced no larger than 1/4 inch pieces, they are moist, with some cohesion] diet and could have requested puree. Staff were directed to monitor, document, and report to the physician as needed for signs and symptoms of swallowing problems.

R10's undated nursing assistant Care Guide included mechanical soft diet with pureed meat.

R10's Nutrition Evaluation dated 4/16/20, identified a mechanical soft diet with pureed meat. Speech therapy recommended to, "have all meats ground, unless resident request pureed for preference."

R10's Oral/Dental Evaluation dated 7/14/20, indicated R10 had full upper and lower dentures.

During observation on 9/25/20, at 12:42 p.m. R10 was observed to be coughing while eating. At 12:47 p.m. it was noted R10 was eating a regular hamburger patty on a bun. R10 stated it was hard to eat because she did not have her dentures in. She had requested the regular patty as the staff had grilled out the burgers and she desired one. R10 continued to cough while eating, no one checked to see if she was alright,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29	F 689		

nor did anyone bring her dentures.

R10's lunch tray ticket included, "Mechanical soft texture and to provide ground grilled hamburger, potato salad, no raw veggies, beans, shredded lettuce."

When interviewed on 9/25/20, at 1:06 p.m. dietary aide (DA)-A stated residents who require a mechanical soft diet should have been provided with ground meat. R10 coughing is something she normally does while eating.

When interviewed on 9/25/20, at 1:12 p.m. cook (CK)-A stated, a mechanical soft diet should have ground meat, no bread or hard vegetables. The cook is the person responsible to ensure the correct diet is served.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated R10 does cough at meals, she was unaware R10 did not have dentures in. NA-F stated if someone is coughing like that, they should go get a nurse to assess if no nurse was in the dining room.

When interviewed on 9/25/20, at 1:34 p.m. R10 stated she normally gets a ground burger, but today got a regular whole burger as they were grilling them. R10 stated she normally wore her dentures, but forgot them today. Staff sometimes have to remind her to put them in or help her with them. At 1:39 p.m. R10 was coughing and NA-H asked her if she was ok.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated resident's diets could be upgraded if they wished for an upgrade, but would have to sign a risk versus benefits statement. R10 did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30	F 689		

a risk versus benefits statement signed nor was she given the risks of choking when provided with a regular hamburger today.

When interviewed on 9/25/20, at 3:08 p.m. Cook-A stated they have a file of each resident who had signed a risk versus benefits statement for a diet upgrade, then if they ask for an upgrade they can provide it. R10 did not have one of these. R10 should have been provided the ground meat diet as ordered and not a regular hamburger.

R10's Diet Requisition Form provided by Cook-A and dated 3/31/20, had been completed by speech therapy and indicated R10 was to have a Mechanical Soft/Ground Meat NDD2 diet consistency and patient could downgrade to pureed food if desired.

When interviewed on 9/28/20, at 10:21 p.m. the registered dietician (RD) stated if a resident were coughing during a meal it should be reported to the DON, food service director and speech therapy. This had not been done for R10. The facility should not provide an upgraded texture diet without risks being explained to the resident and a form signed.

When interviewed on 9/28/20, at 2:37 p.m. the DON and RN-A stated it is important to provide the correct diet texture for residents with swallowing problems. A nurse should be notified if a resident is coughing.

R5's quarterly MDS dated 9/4/20, indicated no cognitive impairment with diagnoses including, stroke, epilepsy. The MDS noted R5 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 31	F 689		

coughing and choking during meals or when swallowing medications during the assessment period. The MDS further indicated supervision, oversite, set up when eating and mechanically altered textures.

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.

R5's Care Assessment Area Worksheet (CAA) dated 1/20/20, indicated R5 required a mechanically altered diet. There was no analysis completed, but was noted to proceed to care planning.

R5's care plan dated 3/20/20, indicated R5 was at risk for nutritional alteration related to chronic pain front thorax and diet restriction for NDD3 diet. Staff were directed to monitor, document and report to physician for signs or symptoms of dysphagia when eating.

R5's Progress note dated, 1/25/19, indicated her diet was changed to NDD3 by Speech therapy.

R5's Nutritional Evaluation dated 9/4/20, identified a diet order for NDD3, Dysphagia Advanced diet level 3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32	F 689		

R5's Care guide for staff indicated a regular diet and independent in dining room which is different from MDS 9/4/20, CAA 1/20/20, Medical Record, physician order and care plan.

R5's lunch tray ticket included a diet order for Dysphagia Advanced diet (NDD3). The tray ticket further directed to provide chopped, grilled hamburger on bun, potato salad, no raw vegetables, backed beans, no bacon, shredded lettuce, soft ice cream and milk.

During an observation on 9/25/20, at 12:50 p.m. R5 sat alone at a table and was noted to cough while she ate her meal. R5's plate contained a whole hamburger with a wedge of lettuce that covered the burger on a bun and potato chips. There were various staff throughout the dining area including nursing and dietary, but no one stopped to see why R5 was coughing. At 12:52 p.m. R5 was observed to be shaking and asked for someone get a nurse because she was having a seizure. Staff came and brought R5 out of the dining room.

When interviewed on 9/25/20, at 1:06 p.m. DA-A stated R5 should have received ground meat, beans, potato salad, soft cooked vegetables. R5 should not have had a bun, the burger should have been ground and should not have received potato chips or whole leaf lettuce.

When interviewed on 9/25/20, at 1:10 p.m. R5 stated she has occasional seizure that are like, "spells," and has no diet restrictions.

When interviewed on 9/25/20, at 1:12 p.m. Cook-A stated the facility provided NDD3, NDD2 and pureed textures. A mechanical diet should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33	F 689		

have ground meat, no bread or hard vegetables. For the noon meal provided on 9/25/20, a mechanical texture should have included, no bun, ground hamburger, potato salad and beans. It was the cook's responsibility to make sure a resident is getting the appropriate texture.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated staff should check on residents who are coughing and should get a nurse. R5 should have received the correct diet and did not know who gave her the wrong diet.

When interviewed on 9/25/20, at 1:40 p.m. Dietary Aide-A reported both dietary and nursing aides deliver meal trays.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated a resident is ok to be provided an upgraded texture if a risk and benefit form had been signed. The resident should be given the order from the physician if there is no signed risk and benefit form. R5 did not have a signed form.

On 9/25/20 at 3:08 p.m. Cook-A- stated R5 should have received the ordered diet, but did not, the Cook is responsible for providing the correct diet.

The facility Refusal of Care/Interventions, Risk and Benefits policy dated 9/11, identified a resident would be informed of the risk and benefits of necessary care and given the opportunity regarding their decision in the plan of care. The resident would be approached 2-3 times and if resident continued to refuse, documentation should be made on the Refusal of Care Interventions Risk and Benefits and reviewed quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	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 soft, well-cooked vegetables. Vegetables should be less than 1/2 inch and should be easily mashed with a fork.	F 689		
F 725 SS=F	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 at §483.70(e). §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: (i) Except when waived under paragraph (e) of	F 725		11/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 35 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide for the individualized care planned needs for 8 of 8 residents (R5, R7, R4, R1, R3, R8, R13 and R12), 12 of 15 staff (LPN-B, LPN-A, LPN-D, NA-D, NA-C, NA-J, NA-B, NA-F, NA-A, RN-A, HSK-A and NA-C) and 1 of 3 family members (FM)-A, reviewed for sufficient staffing. This had the potential to affect all 42 current residents. Findings include: R5's quarterly Minimum Data Set dated 9/4/20, included cognitively intact with diagnoses of stroke with paralysis or weakness on one side of the body and a seizure disorder. R5 required physical assistance from staff for toileting and bathing. R5 Care Assessment Worksheet (CAA) dated 1/20/20, included, R5 extensive assistance with activities of daily living (ADL) including bathing and toileting. R5's care plan updated 8/12/20, included, R5 needed assistance with toilet use and shower/bath with one assist twice a week on Sunday and Wednesday evenings with skin	F 725	F725=F. Based on observation, interview, and document review, the facility failed to ensure sufficient staff to provide for the individualized care planned needs for 8 of 8 residents, 12 of 15 staff, and 1 of 3 family members, reviewed for sufficient staff. This has the potential to affect all 42 current residents. Pleasant Manor has the responsibility to provide services by sufficient numbers to promote resident rights and dignity. The policy in regards to completing a Facility Assessment has been reviewed and remains appropriate. The facility completed a facility assessment to assess and identify appropriate staffing needs for the current level of care and provide guidance for future staffing needs for the appropriate level of care. Daily staffing assignments will be signed off by Administrator or Director of Nursing daily. Education will be completed with IDT through QAPI and with facility staff through an all-staff meeting regarding executed facility assessment and daily review of staffing. Administrator or designee will perform audits weekly x 4 weeks, monthly x 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 not getting the timely care she needed with toileting, bathing and hygiene as there was not enough staff. R5 did complain about this. 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. When interviewed on 9/24/20, at 3:22 p.m. a nursing assistant (NA)-D stated R5 required assistance with bathing and toileting, but often she had to wait for assistance as they do not have enough staff to get to everyone timely. Sometimes they have to skip R5's bath as they do not have enough 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. R5's Grievance/Concern Report included, R5 did not receive a bath or shower on 7/22/20. NA-I stated, "R5's shower did not get done on Sunday evening due to time." NA-J stated, "R5's shower did not get done due to running out of time. Her bath requires two aids which [NA-I] and I were the	F 725	months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed: 11/2/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 37	F 725		

only two on the floor until 6 p.m. After 6 we still had a lot to do and ended up not having enough time to get in the bath R5 wanted. There was also another shower that was supposed to get done that we never got done."

Shower/bath records dated July to September 2020: R5 received a shower on 7/19 but not again until 8/17/20, and then not again until 8/24//20. R5 received a bath on 9/13/20, but not again until 9/21/20.

Review of R5's call light log from 9/1/20 (6:53 p.m.) to 9/29/20 (2:24 p.m.), indicated, R5 used the call light 166 times. Of the 166 instances, the wait time was over 20 minutes on 69 occasions or 41.5% of the time.

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.

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.

R7's care plan dated 7/29/20, included, R7 required assistance for, "Bathing with max to dependent assist, dressing with max assist, personal hygiene set-up with minimal assist, occasionally incontinent, and requires assistance with toilet use."

When interviewed on 9/24/20, at 1:31 p.m. a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 38	F 725		

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 night shift is customarily staffed with two NA's and 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 the individual needs of each resident. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 39	F 725		

morale among staff and residents is low because of this.

R7's call light response time logs dated from 9/22/20, at 3:51 a.m. to 9/28/20, 9:25 a.m. showed the call light was engaged 51 times over the seven day period. Of the 51 call light alerts initiated, 11 (or 21.5%) of these alerts took over 15 minutes to receive a response. Seven (or 14%) of these alerts took longer than 20 minutes to receive a response.

R4's admission Minimum Data Set (MDS) dated 6/29/20, included, moderate cognitive impairment with diagnoses including diabetes, dementia and arthritis. R4 required extensive assistance with toileting and limited assistance with personal hygiene. R4 was not on a toileting program and was occasionally incontinent of urine (less than 7 times during the assessment period).

R4's incontinence Care Area Assessment (CAA) dated 7/1/20 indicated, "Resident triggers for urinary incontinence r/t [related to] need for assistance with toilet use and bladder incontinence." "She is in PT [physical therapy] and OT [occupational therapy] at this time with the goal of returning to the community. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's significant change MDS dated 8/27/20, included severe cognitive impairment, was totally dependent upon staff for toileting and personal hygiene and was always incontinent of urine.

R4's incontinence CAA dated 8/28/20 included,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 40	F 725		

"Resident triggers for urinary incontinence r/t toilet use and bladder incontinence. Resident has declined in both mobility and cognitive function. She has recently enrolled in hospice for end of life cares. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's only Bowel and Bladder assessment in the medical record was dated 6/24/20, and indicated R4 was continent of bowel and bladder.

R4's care plan dated 6/26/20, included, "Alteration with elimination." Staff were directed to, "Assist of 1 with toileting." The care plan had not been updated since 6/26/20, even though the 8/27/20, MDS noted a decline in urinary incontinence to totally incontinent and an increase in assistance needs for toileting and personal hygiene.

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.

During continuous observation on 9/25/20, starting at 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to provide incontinence cares occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. LPN-D then brought R4 to the dining room. Incontinence cares were not provided. At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 41	F 725		

1:58 p.m. NA-F and NA-B assisted R4 into bed and changed R4's visibly wet brief.

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 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 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.

R4's call light log from 9/1/20 - 9/29/20 revealed R4 used the call light 20 times. Of the 20 instances the wait time was over 10 minutes on five occasions, over 40 minutes on one occasion, and over 60 minutes one occasion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 42	F 725		

R1's quarterly Minimum Data Set (MDS) dated 8/20/20, included, severe cognitive impairment with diagnoses including TBI (traumatic brain injury) and dementia. R1 required extensive assistance with most activities of daily living (ADL's) and did not ambulate. R1 had 2 or more falls with injury since the prior assessment. R1 had a discharge MDS dated 9/16/20.

R1's care plan dated 9/2/20, included, "Fall risk AEB [as evidenced by] multiple falls since admission related to lack of safety awareness secondary to TBI and Dementia with behavioral disturbances." The goal for R1 was listed as, "Resident will be safe and free from serious injury should incident occur." Staff were directed to, "Provide one on one care, such as taking outside and wheeling her down the hall."

The facility provided a running list of R1's falls from 7/21/20 thorough 9/24/20, which indicated R1 had fallen in the facility 17 times in that time frame. 7/14/20, 7/31/20, 8/1/20, 8/5/20, 8/6/20, 8/11/20, 8/12/20, 8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20, 8/21/20, 8/29/20, 9/3/20, 9/14/20 and 9/15/20.

Hospital discharge summary dated 9/16/20, indicated R1 was transferred to the hospital on 9/15/20 after sustaining a fall related to increased agitation. Summary details R1 incurred a fractured skull and finger.

R1's progress notes from 9/16/20 to 9/21/20, revealed:
-9/16/20, at 4:36 p.m. R1 returned to the facility from the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 43	F 725		

R1's progress note dated 9/16/20, at 5:35 p.m. included R1 had attempted to crawl out of bed several times after returning from the hospital. Facility transferred R1 to her wheelchair, R1 then started to yell out and reported of pain in neck and back. R1 reported to facility of pain in her neck and back. R1 started to stand up from her wheelchair. Facility initiated a 2 to 1 staff to R1 ratio as the facility determined R1 was not safe. R1's physician was contacted and consulted and confirmed for the R1 to be sent back to the hospital. R1's guardian was informed of the transfer situation.

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.

R1's progress noted dated 9/16/20, at 6:28 p.m. included, R1 was noted to have continued marked behaviors: swore at staff, attempted to put herself onto the floor, yelling and hollering louder than her usual, R1 was extremely agitated and 1:1, 2:2, 3:3 were attempted and R1 remained aggressive towards staff. Facility called 911 to send R1 to emergency department (ED) for further evaluation per physician's orders.

When interviewed on 9/24/20, at 1:00 p.m. NA-B stated there were times when R1 required one on one attention, but they only had one or two staff to cover a unit of 30 residents, so this was not possible.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated they did not have enough help to watch R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

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F 725	Continued From page 44 all the time and she fell a lot. When interviewed on 9/24/20, at 2:56 p.m. the emergency room social worker stated the facility would not take R1 back to the facility because they did not have enough help to watch her well enough. When interviewed on 9/24/20, at 3:22 p.m. NA-D stated R1 required a significant amount of staff time to prevent her from falling and they just did not have the time to stay with her all the time. NA-D stated she worked the day shift and often when arriving for her shift would find R1, "sopping wet," in her incontinent brief. When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated there was not enough staffing to supervise R1 and keep her safe as she required individual attention. When interviewed on 9/28/20, at 10:10 a.m. the DON stated due to limited staffing R1's needs could not be met at the facility, therefore R1 could not be readmitted after her last admission to the hospital. R3's admission minimum data set (MDS), dated 8/15/20, revealed R3 had moderate cognitive impairment. R3 required supervision and one staff physical assistance for eating. R1's diagnosis included a stroke. R3 had the following swallowing concerns: loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, and coughing during meals or when	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

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F 725	Continued From page 45	F 725		

swallowing medications.

R3's care plan, last updated 9/24/20, directed staff, "The resident needs a calm, quiet meal time with adequate eating time. The resident requires all meals in the dining room r/t [related to] close supervision-not to receive meals until supervision is provided."

When interviewed on 9/24/20, at 12:56 p.m. NA-A stated she worked day shift and considered it, "understaffed." NA-A reported residents waited to be provided morning cares prior to breakfast, especially if they required two staff and assistance with mechanical lift. NA-A stated, R3 required individual assistance for cueing him to not eat too quickly or take too big of a bite and to get enough fluid. NA-A noted R3 often had to wait over 40 minutes to eat until they had enough staff in the dining room to help him.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated, R3 required staff to closely monitor to make sure he ate the amount he should. Often no staff were available to help, he would sit and look around the room, waiting for his plate of food.

When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated, there were several residents that required assistance in the dining room and it was difficult to figure out how to feed R3. R3 required help the entire time due to choking precautions and required assistance the entire meal time.

During observation on 9/25/20, at 12:21 p.m. R3 wheeled self into the dining room. R3 rolled his wheel chair back and forth at the table, looking around until his meal was brought to him at 12:41 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 46	F 725		

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated there is never enough staff in the dining room to feed everyone. "On a good day, we are lucky to have 2 aides to assist all the residents."

R8's admission MDS, dated 8/10/20, included, R8 was cognitively intact with a diagnosis of Parkinson's disease. R8 required physical assistance of 2 staff for transfers and supervision and one person physical assistance for toileting.

R8's care plan, last revised 8/24/20, directed staff, "Alteration in elimination r/t [related to] Parkinson's" and, "Assist of 1 with toileting as needed for hygiene."

When interviewed on 9/24/20, at 12:23 p.m. 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.

When interviewed on 9/28/20, at 10:37 a.m. R8 stated there was not enough staff to help her when she needed it. R8 stated she has problems with stiffness and decreased ability to do things on her own when her Parkinson's medication was late. R8 stated staff tell her they have a half hour

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 47	F 725		

on each side of the time her medication is due, but it is often over that. R8 stated staff tell her they do not have enough staff to get it to her on time. R8 stated she does not get enough help to the bathroom, she often has to wait 20-40 minutes to get on or off the toilet. This causes her back to hurt and she gets even more still and unable to care for herself even more.

R8's medication administration record (MAR), dated August 2020, included an order for Carbidopa-Levodopa (a medication for treating Parkinson's disease symptoms such as muscle stiffness, tremors, spasms, and poor muscle control) five times daily; 5:55 a.m., 10:00 a.m., 4:00 p.m., 7:30 p.m. and 11:30 p.m. R8 was noted as being administered the medications at each opportunity, but the time administered was not noted.

When interviewed on 9/28/20, at 10:58 a.m. LPN-D stated R8 wanted her medications on time. LPN-D stated R8 reported concerns with getting her medications on time in the evening.

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.

R13's care plan, dated 7/3/20, incontinence and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 48	F 725		

risk for skin breakdown and required staff assistance. The care plan indicated to keep the call light in reach and answer promptly.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated R13 was totally dependent on staff for cares. Sometimes R13 had to stay in bed for breakfast as they didn't have enough staff to get her up before breakfast. R13 would prefer to get up, but is agreeable when they need her to be. Often R13 would be, "saturated" by the time they were able to attend to her after breakfast.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated when coming on for the afternoon shift they would find R13 soaked in urine. NA-D was often the only staff on afternoons who was competent to use the mechanical lift needed to get R13 up, and due to this, often R13 had to stay in bed at supper time. This would upset R13, but they just didn't have enough help to always get her up.

When interviewed on 9/28/20, at 11:05 a.m. R13 stated she is incontinent of urine due to her 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, between 50 and 60 minutes on 5 occurrences and over 60 minutes on four occurrences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 49	F 725		

R12's quarterly MDS dated 8/14/20, included, R12 had moderate cognitive impairment. R12 was on hospice services and required oxygen care. R12's diagnoses included coronary artery disease, asthma/chronic obstructive pulmonary disease or chronic lung disease and respiratory failure.

R12's medication and treatment administration report (MAR/TAR), dated August 2020, directed staff, "Connect 02 1.5 L [liters]/min [minute] at bedtime." and "Oxygen at 1.5L/min per nasal cannula while at rest and at night. This was not marked as completed on the night of 9/4/20 and 9/17/20. The MAR/TAR directed "Ensure resident has bipap on every overnight, every night shift for cpap placement. Please ensure Cpap is in place every hour overnight." This was not marked as completed on 9/4/20 and 9/17/20. and "Bipap-Nurse must put on use daily when sleeping and at night." This was not marked as completed the night of 9/4/20 and 9/17/20.

On 9/24/20, at 3:45 p.m. LPN-B stated, R12's and family had concerns about staffing. LPN-B R12 was, "slower," and "needier," than other residents.

On 9/25/20 at 10:39 a.m. a family member of R12, (FM)-A stated she monitored R12's care through video. R12 wore a bipap mask at night and oxygen nasal cannula during the day to assist with respiratory and breathing issues. FM-A would notice times R12's bipap or oxygen was not applied, or not applied properly for significant amounts of time, noting recent example between 3:20 a.m. to 3:50 a.m.; 5:00 a.m. to 7:10 a.m., and 10:10 p.m. to 1:17 a.m. on 9/24/20. FM-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 50	F 725		

reported, during these instances, she would call the facility to alert staff, without response. During the interview, R12 noted she did not feel well when she was not getting the oxygen she needed, like she was in a "daze". FM-A reported R12 was deteriorating both cognitively and physically and was more confused when not on the oxygen. FM-A stated, on 9/18/20 to 9/19/20 she noted no camera activity, indicating no movement detected, in R12's room between 11:34 p.m. and 4:09 p.m. FM-A noted R12 required frequent monitoring to ensure her bipap was on properly. FM-A reported R12 had told her she felt like a burden to staff. FM-A reported she had informed the director of nursing of her concerns and there was no resolution or improvement.

R12's call light log, dated 9/1/20 to 9/29/20, included, R12 activated the call light 66 times. Eleven of those were answered in 10 to 20 minutes. Six were answered between 20 to 30 minutes. Six were answered between 30 to 40 minutes. One was answered between 40 and 50 minutes. Six were answered in over 60 minutes

When interviewed on 9/24/20, at 12:23 p.m. LPN-A stated there were not enough staff to care for residents. LPN-A explained there were sometimes only one aide on west side of the care center. Residents were not getting the timely care they needed with timely toileting, bathing and hygiene. The workload was stressful and contributing to staff burnout and turnover. LPN-A stated, she had discussed concerns with DON and administrator and there had been no resolution. LPN-A reported she helped the nursing assistants with cares when she was able but was busy with completing treatments and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 51	F 725		

medication pass for residents. LPN-A reported there was an overall concern with resident not getting the timely assistance with bathing and hygiene.

When interviewed on 9/24/20, at 1:31 p.m. NA-C reported she was pulled away from her nursing assistant duties to help with electronic medical appointments and wound rounds. There was not sufficient nursing staff to provide oral care and peri-cares for residents. The nurses were too busy with their own duties to assist. Most of the time baths and showers were missed and residents were not assisted with morning and evening cares when they preferred. Staff would chart a resident refused a bath, when the resident had not been offered, or chart a resident was bathed, when they were not bathed. This had been reported to both the DON and administrator with no changes.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated she worked the night shift and there were times when she would be the only nurse aid in the building. Resident call lights were on for extended periods of time- sometimes over an hour. They just could not get to them timely. At meal times residents complain of cold food. "Short staffing is a daily occurrence." This had been reported to the administrator but was told there was nothing they could do about it.

When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated there was one or two aides for 30 residents. Nurses were expected to provide personal cares for 5 residents each shift in addition to their regular duties. Sometimes, they were not able to make sure resident treatments were completed. When staff come from a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 52	F 725		

staffing agency, they are reluctant to return as they do not have enough time to complete all of their work. LPN-B had reported this concern to management and was told they had enough staff.

When interviewed on 9/25/20, at 11:12 p.m. HSK-A stated nursing assistance seem to be, "burned out," because they do not have enough time to meet resident needs.

When interviewed on 9/28/20, at 3:36 p.m. the administrator, assistant administrator, DON and RN-A were interviewed together. There was no facility assessment to determine the specific staffing needs to meet resident care planned needs. Typically, there should be 1 nursing assistant per 10 residents. DON stated there were residents who complained about call light wait times, particularly at night time. RN-A stated, "The staff have made it seem so drastic" but noticed "a lot of standing around." The administrator noted she was working on team dynamics and culture change in response to staffing concerns. The administrator reported she was committed to improving the staffing situation and chipping in within her abilities. DON reported she felt there was an adequate number of staff but felt the communication was poor. DON reported there was a situation where there was too many staff and less work got done. RN-A reported there was fewer staff because the census was down.

The facility staffing policy, dated 10/17, directed staff, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care ad services for all residents in accordance with resident care plans and assessment." and "Staffing numbers and the skill

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 53 requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care."	F 725		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prepare food in accordance with residents needs for 2 of 3 residents (R5 and R10) reviewed who required modified texture diets. Findings include: 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. 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 consistency, small bites thorough mastication (chewing), swallow bites before taking another bite/sip, slow pacing, single sips, alternate between liquids/solids. The report indicated further analysis would be required to determine if	F 805	F805=D. Based on observation, interview, and document review, the facility failed to prepare food in accordance with residents needs for 2 of 3 residents reviewed and required modified texture diets. Pleasant Manor residents have the right to receive food prepared in a form designed 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. The associated policies related to serving 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 diet textures during meal time. Culinary Director/Dietitian or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to	11/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 54 R10 would be appropriate 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. R10's care plan dated 4/1/20, included, risk for nutritional alteration related to coughing during meals; had diet restrictions which included NDD2 [National Dysphagia Diet, level 2- meats are to be ground or are minced no larger than 1/4 inch pieces, they are moist, with some cohesion] diet and could have requested puree. Staff were directed to monitor, document, and report to the physician as needed for signs and symptoms of swallowing problems. R10's undated nursing assistant Care Guide included mechanical soft diet with pureed meat. R10's Nutrition Evaluation dated 4/16/20, identified a mechanical soft diet with pureed meat. Speech therapy recommended to, "have all meats ground, unless resident request pureed for preference." R10's Oral/Dental Evaluation dated 7/14/20, indicated R10 had full upper and lower dentures. During observation on 9/25/20, at 12:42 p.m. R10 was observed to be coughing while eating. At 12:47 p.m. it was noted R10 was eating a regular hamburger patty on a bun. R10 stated it was hard to eat because she did not have her dentures in. She had requested the regular patty as the staff had grilled out the burgers and she desired one. R10 continued to cough while eating, no one checked to see if she was alright,	F 805	ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 11/2/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 55	F 805		

nor did anyone bring her dentures.

R10's lunch tray ticket included, "Mechanical soft texture and to provide ground grilled hamburger, potato salad, no raw veggies, beans, shredded lettuce."

When interviewed on 9/25/20, at 1:06 p.m. dietary aide (DA)-A stated residents who require a mechanical soft diet should have been provided with ground meat. R10 coughing is something she normally does while eating.

When interviewed on 9/25/20, at 1:12 p.m. cook (CK)-A stated, a mechanical soft diet should have ground meat, no bread or hard vegetables. The cook is the person responsible to ensure the correct diet is served.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated R10 does cough at meals, she was unaware R10 did not have dentures in. NA-F stated if someone is coughing like that, they should go get a nurse to assess if no nurse was in the dining room.

When interviewed on 9/25/20, at 1:34 p.m. R10 stated she normally gets a ground burger, but today got a regular whole burger as they were grilling them. R10 stated she normally wore her dentures, but forgot them today. Staff sometimes have to remind her to put them in or help her with them. At 1:39 p.m. R10 was coughing and NA-H asked her if she was ok.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated resident's diets could be upgraded if they wished for an upgrade, but would have to sign a risk versus benefits statement. R10 did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

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F 805	Continued From page 56	F 805		

a risk versus benefits statement signed nor was she given the risks of choking when provided with a regular hamburger today.

When interviewed on 9/25/20, at 3:08 p.m. Cook-A stated they have a file of each resident who had signed a risk versus benefits statement for a diet upgrade, then if they ask for an upgrade they can provide it. R10 did not have one of these. R10 should have been provided the ground meat diet as ordered and not a regular hamburger.

R10's Diet Requisition Form provided by Cook-A and dated 3/31/20, had been completed by speech therapy and indicated R10 was to have a Mechanical Soft/Ground Meat NDD2 diet consistency and patient could downgrade to pureed food if desired.

When interviewed on 9/28/20, at 10:21 p.m. the registered dietician (RD) stated if a resident were coughing during a meal it should be reported to the DON, food service director and speech therapy. This had not been done for R10. The facility should not provide an upgraded texture diet without risks being explained to the resident and a form signed.

When interviewed on 9/28/20, at 2:37 p.m. the DON and RN-A stated it is important to provide the correct diet texture for residents with swallowing problems. A nurse should be notified if a resident is coughing.

R5's quarterly MDS dated 9/4/20, indicated no cognitive impairment with diagnoses including, stroke, epilepsy. The MDS noted R5 had

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F 805	Continued From page 57	F 805		

coughing and choking during meals or when swallowing medications during the assessment period. The MDS further indicated supervision, oversite, set up when eating and mechanically altered textures.

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.

R5's Care Assessment Area Worksheet (CAA) dated 1/20/20, indicated R5 required a mechanically altered diet. There was no analysis completed, but was noted to proceed to care planning.

R5's care plan dated 3/20/20, indicated R5 was at risk for nutritional alteration related to chronic pain front thorax and diet restriction for NDD3 diet. Staff were directed to monitor, document and report to physician for signs or symptoms of dysphagia when eating.

R5's Progress note dated, 1/25/19, indicated her diet was changed to NDD3 by Speech therapy.

R5's Nutritional Evaluation dated 9/4/20, identified a diet order for NDD3, Dysphagia Advanced diet level 3.

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	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 805	Continued From page 58	F 805		

R5's Care guide for staff indicated a regular diet and independent in dining room which is different from MDS 9/4/20, CAA 1/20/20, Medical Record, physician order and care plan.

R5's lunch tray ticket included a diet order for Dysphagia Advanced diet (NDD3). The tray ticket further directed to provide chopped, grilled hamburger on bun, potato salad, no raw vegetables, backed beans, no bacon, shredded lettuce, soft ice cream and milk.

During an observation on 9/25/20, at 12:50 p.m. R5 sat alone at a table and was noted to cough while she ate her meal. R5's plate contained a whole hamburger with a wedge of lettuce that covered the burger on a bun and potato chips. There were various staff throughout the dining area including nursing and dietary, but no one stopped to see why R5 was coughing. At 12:52 p.m. R5 was observed to be shaking and asked for someone get a nurse because she was having a seizure. Staff came and brought R5 out of the dining room.

When interviewed on 9/25/20, at 1:06 p.m. DA-A stated R5 should have received ground meat, beans, potato salad, soft cooked vegetables. R5 should not have had a bun, the burger should have been ground and should not have received potato chips or whole leaf lettuce.

When interviewed on 9/25/20, at 1:10 p.m. R5 stated she has occasional seizure that are like, "spells," and has no diet restrictions.

When interviewed on 9/25/20, at 1:12 p.m. Cook-A stated the facility provided NDD3, NDD2 and pureed textures. A mechanical diet should

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F 805	Continued From page 59	F 805		

have ground meat, no bread or hard vegetables. For the noon meal provided on 9/25/20, a mechanical texture should have included, no bun, ground hamburger, potato salad and beans. It was the cook's responsibility to make sure a resident is getting the appropriate texture.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated staff should check on residents who are coughing and should get a nurse. R5 should have received the correct diet and did not know who gave her the wrong diet.

When interviewed on 9/25/20, at 1:40 p.m. Dietary Aide-A reported both dietary and nursing aides deliver meal trays.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated a resident is ok to be provided an upgraded texture if a risk and benefit form had been signed. The resident should be given the order from the physician if there is no signed risk and benefit form. R5 did not have a signed form.

On 9/25/20 at 3:08 p.m. Cook-A- stated R5 should have received the ordered diet, but did not, the Cook is responsible for providing the correct diet.

The facility Refusal of Care/Interventions, Risk and Benefits policy dated 9/11, identified a resident would be informed of the risk and benefits of necessary care and given the opportunity regarding their decision in the plan of care. The resident would be approached 2-3 times and if resident continued to refuse, documentation should be made on the Refusal of Care Interventions Risk and Benefits and reviewed quarterly.

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F 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 soft, well-cooked vegetables. Vegetables should be less than 1/2 inch and should be easily mashed with a fork.	F 805		

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	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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F 000	INITIAL COMMENTS On 9/24/20, 9/25/20 and 9/28/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5090056C at F689 H5090057C at F677 and F725 H5090059C at F677, F686 and F725 The following complaints were found to be unsubstantiated: H5090055C and H5090058C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		11/2/20

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

Electronically 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.

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 1 resident (R7) reviewed for dignity concerns.	F 550	F550=D. Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 1 resident (R7) reviewed for dignity concerns.	

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	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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F 550	Continued From page 2 Findings include: R7's admission Minimum Date Set (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. 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. R7's care plan dated 7/29/20, included, R7 required assistance for, "Bathing with max to dependent assist, dressing with max assist, personal hygiene set-up with minimal assist, occasionally incontinent, and requires assistance with toilet use." 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.	F 550	The residents of Pleasant Manor have the right to receive care in a dignified manner. It is the responsibility of all staff of the facility to ensure the residents' plan of care promotes their dignity and resident rights. The associated policies related to providing care in a dignified manner were reviewed and remain appropriate. R7's plan of care for toileting was reviewed and remains appropriate for currently level of function. All resident's toileting plans have been reviewed, discussed as an IDT and toileting plans appear to be appropriate at this time. IDT additionally will implement a Resident Advocate Program that will assist in promoting timely response to resident concerns. Education of executing a toileting plan of care will be completed for all nursing staff and IDT will be educated on Resident Advocate Program. Administrator/DON or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Date of completion: 11/2/2020	

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F 550	Continued From page 3	F 550		

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 and 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 state there is insufficient staff to meet the individual needs of each resident. The morale among staff and residents is low because of this. R7 being incontinent due to not being able to get to her timely is a dignity issue.

R7's call light response time logs dated from 9/22/20, at 3:51 a.m. to 9/28/20, 9:25 a.m. showed the call light was engaged 51 times over the seven day period. Of the 51 call light alerts initiated, 11 (or 21.5%) of these alerts took over 15 minutes to receive a response. Seven (or 14%) of these alerts took longer than 20 minutes to receive a response.

During a phone call interview on 9/28/20, at 3:30 p.m. the administrator stated they do not have a staffing or facility assessment in place to assist in determining staffing needs at this time. The administrator stated current staffing rations include one staff member for every ten residents. "More comradery and better communication," was needed among the staff. These measures would improve care. The administrator stated that they are working on this initiative.

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	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to issue a written bed-hold notice upon transfer to the hospital for 1 of 3 residents (R1) reviewed for hospitalizations. Findings include:	F 625	F625=D. Based on document review and interview, the facility failed to issue a written bed-hold notice upon transfer to the hospital for 1 of 3 residents (R1) reviewed for hospitalizations. Prior to transfer, it is the responsibility of the Pleasant Manor staff to offer a written	11/2/20

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	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 5 R1's admission Minimum Data Set (MDS) dated 5/20/20, indicated R1 was admitted to facility on 5/14/20 with a discharge assessment-return anticipated MDS dated, 9/16/20. R1's progress note dated 9/16/20, at 6:24 p.m. included, R1 was transferred to the hospital and a full report was given to the police and transport teams. However a bed hold notice was not found in R1's medical record. When interviewed on 9/24/20, at 3:07 p.m. R1's guardian reported she had not been provided a bed hold notification and was unaware of the possibility to hold the bed for R1. When interviewed on 9/28/20, at 2:09 p.m. the interim director of nursing (DON) verified a written bed hold notice was not completed for R1. Facility policy titled, Transfer or Discharge, Emergency revised on 08/2018, indicated under bullet number 4: "The business office is responsible for: b. Informing the resident, or his or her representative (sponsor) of our facility's readmission appeal rights, bed-holding policies, ect."	F 625	bed-hold to the resident being transferred. The bed-hold policy has been reviewed and remains appropriate. All nurses and IDT members will be educated on the bed-hold policy and the steps to carry out offering a bed-hold during a transfer to the hospital. Administrator or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 11/2/2020	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide incontinence	F 677	F677=D. Based on observation, interview, and document review, the	11/2/20

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F 677	Continued From page 6 care timely, and failed to reassess continence status after a significant change for 1 of 3 residents (R3) reviewed for incontinence. Findings include: R4's admission Minimum Data Set (MDS) dated 6/29/20, included, moderate cognitive impairment with diagnoses including diabetes, dementia and arthritis. R4 required extensive assistance with toileting and limited assistance with personal hygiene. R4 was not on a toileting program and was occasionally incontinent of urine (less than 7 times during the assessment period). R4's incontinence Care Area Assessment (CAA) dated 7/1/20 indicated, "Resident triggers for urinary incontinence r/t [related to] need for assistance with toilet use and bladder incontinence." "She is in PT [physical therapy] and OT [occupational therapy] at this time with the goal of returning to the community. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode." R4's significant change MDS dated 8/27/20, included severe cognitive impairment, was totally dependent upon staff for toileting and personal hygiene and was always incontinent of urine. R4's incontinence CAA dated 8/28/20 included, "Resident triggers for urinary incontinence r/t toilet use and bladder incontinence. Resident has declined in both mobility and cognitive function. She has recently enrolled in hospice for end of life cares. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with	F 677	facility failed to provide incontinence care timely, and failed to reassess continence status after a significant change for 1 of 3 residents (R4) reviewed for incontinence. Pleasant Manor staff have the responsibility to provide care to residents who are unable to carry out activities of daily living to promote their health, including assessment during their stay and providing care daily. The associated policies related to toileting plans have been reviewed and remain appropriate. R4's toileting plan was reviewed and updated. All resident's toileting plans have been reviewed, discussed as an IDT and toileting plans appear to be appropriate at this time. Staff will be educated on executing toileting plans per plan of care. DON or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 11/2/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 7	F 677		

current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's only Bowel and Bladder assessment in the medical record was dated 6/24/20, and indicated R4 was continent of bowel and bladder.

R4's care plan dated 6/26/20, included, "Alteration with elimination." Staff were directed to, "Assist of 1 with toileting." The care plan had not been updated since 6/26/20, even though the 8/27/20, MDS noted a decline in urinary incontinence to totally incontinent and an increase in assistance needs for toileting and personal hygiene.

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.

During continuous observation on 9/25/20, starting at 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to provide incontinence cares occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. LPN-D then brought R4 to the dining room. Incontinence cares were not provided. At 1:58 p.m. NA-F and NA-B assisted R4 into bed and changed R4's visibly wet brief.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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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. 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, 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."	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		11/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

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F 686	Continued From page 9 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide repositioning timely for 1 of 3 residents (R4) reviewed who were at risk of developing pressure ulcers. Findings include: R4's significant change Minimum Data Set (MDS) dated 8/27/20, included severe cognitive impairment with a diagnosis of dementia. R4 required extensive assist for bed mobility and total staff assistance for transfer. R4 was at risk for pressure ulcer development, but did not have a current pressure ulcer. R4's pressure ulcer Care Area Assessment (CAA) dated 8/28/20 included, "Resident triggers for pressure r/t [related to] need for assistance with bed mobility and bowel and bladder incontinence. Resident is at risk for skin break down r/t cognitive impairment, dx [diagnosis] of HTN [hypertension] and Type 2 DM [diabetes]	F 686	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 residents 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's repositioning plan of care was reviewed and remains appropriate. R4's skin has been reviewed and remains free of skin alterations. All resident's repositioning plans of care have been reviewed, discussed at IDT, and repositioning plans of care remain appropriate. All nursing staff will be educated on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 10 and daily use of ASA [aspirin] and Coumadin [blood thinner]. She is incontinent of bowel and bladder. Resident noted to have scabbed area over skin tear on LLE [lower left extremity]. Skin otherwise intact. Preventative skin measures in place with toileting and repositioning q [every] 2 hours, pressure redistribution cushion to wheelchair and mattress to bed, routine skin cares q [every] AM [morning] and HS [night], and weekly skin inspections." R4's care plan dated 6/26/20 included, "Potential alteration in skin integrity." Staff were directed to, "Monitor skin integrity daily. Weekly skin inspection by nurse. Treatment to open areas per order. Pressure redistribution mattress to bed. Pressure redistribution cushion to wheelchair, chair." Care plan interventions updated 9/1/20. R4's care plan further indicated, "Alteration in mobility related to end of life" with interventions: "Dependent with bed mobility: A1-2 [assist of 1-2 staff]. Maxi lift (Hoyer) [mechanical lift] with transfers. Turn and reposition Q2H [every 2 hours]." Additionally R4's care plan specified, "Alteration in comfort," with an intervention dated 9/8/20: "Position q2hrs [every 2 hours] and PRN [as needed] with pillows for comfort." R4's nursing assistant Care Sheet included, "Assist of 2 w/ [with] Hoyer [mechanical lift]; does not ambulate." The care sheet did not direct staff on how often to assist R4 with turning and repositioning. A Hospice Facility Visit progress note dated 9/3/20 included, "Does verbalize some discomfort to bottom." During continuous observation on 9/25/20,	F 686	repositioning policy. DON or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 11/2/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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F 686	Continued From page 11	F 686		

starting at 10:25 a.m. R4 was attempting to adjust herself in the wheelchair, but was not able to effectively adjust herself. At 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. The 2 staff members offered to recline R4's wheelchair. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to reposition occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining room. At 1:55 p.m. nursing assistant (NA)-F and 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 terrible 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.

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 staff for repositioning." The policy further instructs,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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F 686	Continued From page 12 "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."	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 3 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 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: R1's quarterly Minimum Data Set (MDS) dated 8/20/20, included, severe cognitive impairment with diagnoses including TBI (traumatic brain injury) and dementia. R1 required extensive	F 689	F689=G. Based on observation, interview, and document review, the facility failed to comprehensively assess 3 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 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. Pleasant Manor ensures that the residents' environments remain safe and as free of accident hazards as possible. The facility identifies each resident at risk for accidents and develops a plan of care	10/1/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 13 assistance with most activities of daily living (ADL's) and did not ambulate. R4 had 2 or more falls with injury since the prior assessment. R1 had a discharge MDS dated 9/16/20. R1's falls Care Area Assessment dated 5/22/20, included, "Resident triggers for falls r/t [related to] having impaired balance and daily psychotropic medication use. Resident has decreased mobility following hospitalization for a UTI [urinary tract infection] and increased behaviors. Resident was involved in a MVA [motor vehicle accident] last November and suffered multiple major injuries including but not limited to: skull fractures, TBI, rib fractures, and wrist fractures." "Resident is at increased risk for falls r/t cognitive impairment, agitation, and daily use of psychotropic, anticonvulsant, antihypertensive, and benzodiazepine medications. She is incontinent of bowel and bladder. She does not have a history of falls prior to admission and has not had any falls since admission. Resident was moved to a room closer to the nurses station for safety. Plan to continue to monitor for safety, keep call light in reach, and follow therapy recommendations." The CAA indicated falls would be addressed in the care plan. R1's admission Fall Review Evaluation dated 5/19/20, included a check list of risk factors for falls as identified in the 5/22/20 CAA. However, there was no analysis of fall risk factors or identification of interventions that may mitigate or reduce the chance of R1 falling. R1's care plan dated 9/2/20, included, "Fall risk AEB [as evidenced by] multiple falls since admission related to lack of safety awareness secondary to TBI and Dementia with behavioral	F 689	addressing safety issues and implements procedures to prevent accidents and incidents. The policy related to assessment of falls have been reviewed and remain appropriate. The policy related to modified textured diets has been reviewed and remain appropriate. R4 and R3's incidents have been reviewed, assessed, and plan of care updated. R1 has been discharged from the facility. All resident's incidents have been reviewed, assessed, and plan of care updated appropriately. All resident's diet textures plans of care have been reviewed and remain appropriate. Nurses were educated on post fall evaluation process and IDT was educated on the process of incident review and analysis and expectations regarding timely completion. Culinary staff were educated on proper service of modified textured diets Administrator/DON or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 10/1/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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F 689	Continued From page 14	F 689		

disturbances." The goal for R1 was listed as, "Resident will be safe and free from serious injury should incident occur." Staff were directed to, use one assist for transfers with a standing lift. Place bed on low position. Have fall mats on both sides of bed. Leave door open at all times unless providing cares. Use a tilt-in-space wheel chair for comfort. To be visually supervised when in wheel chair. Provide one on one care, such as taking outside and wheeling her down the hall.

R1's Action Summary dated 7/1/20 to 9/28/20, identified R1 had fallen 17 times on 7/14/20, 7/31/20, 8/1/20, 8/5/20, 8/6/20, 8/11/20, 8/12/20, 8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20, 8/21/20, 8/29/20, 9/3/20, 9/14/20 and 9/15/20. In addition, R1's progress notes dated 7/29/20 and 8/30/20 identified she had fallen, but these were not included on the Action Summary. There were no progress notes or incident reports for the falls identified on the Action Summary which were dated 8/11/20, 8/12/20 (2 falls), 8/19/20, or 9/14/20. Twelve of the falls were identified in the progress notes as being a fall from bed onto the mat next to the bed. These were on 7/31/20, 8/5/20, 8/6/20, 8/16/20 - three times, 8/21/20- 3 times, 8/29/20, 8/30/20, and 9/3/20. 2 falls were identified from a wheel chair on 8/29/20 and 9/15/20. 1 fall from recliner on 7/29/20. There was no documentation to determine the circumstances of the falls that occurred on 7/14/20, 8/11/12, 8/11/20, 8/12/20, 8/19/20 or 9/14/20.

R1's Incident Review and Analysis dated 7/20/20, included, R1 was found on the floor on 7/14/20. Incident Analysis included, "Staff was walking by resident's room and saw resident lying on the floor." "Resident with lack of safety awareness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 15	F 689		

which contributes to resident's fall risks due to diagnosis of unspecified TBI w/o loss of consciousness; Dementia with behavioral disturbance." The follow-up/intervention section listed: proper footwear, evaluation by PT/OT (physical therapy/occupational therapy), bed in lowest position and soft touch call light. Resident to be visually supervised when in wheelchair. Provide tilt-in-space wheelchair with the ability to recline resident when in chair to provide ore comfort. Staff providing 1:1 (one on one) care such as taking her outside and wheeling her down the hall. "Resident with behaviors and often times heard yelling. Resident requires 1:1 attention to staff and to redirect and provide reassurance. Resident is at high fall risk due to lack of safety awareness due to TBI and dementia. Resident also experiences agitation and restlessness and could be the reason of resident's self transferring to get staff's attention to tend to her." These interventions were added to the care plan.

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."

R1's progress note dated 7/31/20, included, "At 8:40 PM writer heard resident calling out from her room and found resident on the floor laying next to her bed." Abrasions were noted to both knees. There was no assessment of this fall. Interventions added were, "All staff will make sure resident's bedroom door is not closed completely and will keep bathroom light on when room is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 16	F 689		

dark." Keeping the bathroom light on when the room is dark was not added to the care plan.

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 had knees on ground and torso was still in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 17	F 689		

bed. Resident was confused and wanted to leave facility."

R1's progress note dated 8/16/20, at 10:35 p.m. included, "Aid called nurse in to find resident sitting on floor with arms on the bed. Resident was wanting to leave facility."

R1's progress note dated 8/16/20, at 10:40 p.m. included, "Resident was on floor sliding off her bed. Resident had just fallen previous to this but slid out of her bed. Resident was waning [sic] to leave facility and calling out to staff "someone get me out of here."

R1's progress note dated 8/21/20, included, "Writer observed resident sitting on floor x 3 on mat next to bed this shift. No injuries noted. Bed at lowest position. Asked resident what happened and resident stated, "Trying to get out of here."

R1's progress note dated 8/29/20, included, "At 2:15 PM writer heard resident yelling from lobby. Writer found resident laying on the floor next to her W/C [wheel chair] yelling "Ow my head." Writer found 1" [inch] x 1.5" abrasion to resident's forehead. Resident was wearing appropriate footwear, foot pedals in place on W/C, and no incontinence noted. Resident unable to describe to writer what happened except that "I fell and hit my head." Cool wet towel was applied to forehead. Then found an abrasion on her knee also.

R1's progress note dated 8/30/20, included, "Writer heard repeated yelling out from resident's room and found resident on the floor next to her bed. Bed was in lowest position, call light within

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

reach, fall mats in place both sides of bed, and resident not incontinent."

R1's progress note dated 8/30/20, noted a bruise on right index finger and a scrape on her head. There was no incident report or assessment to determine when these injuries occurred.

R1's progress note dated 8/31/20, included, the physician had been updated on bruise to right index finger.

R1's progress note dated 9/2/20, included, "Ice to sore right finger."

R1's treatment record identified staff were to monitor right index finger related to a fall. However, it did not identify which fall caused this injury.

R1's progress note dated 9/3/20, included, "Writer heard resident yelling from her room and when writer arrived resident was sitting on the floor next to her bed yelling, "Help me get back up. Bed was in lowest position with fall mats in place and call light in reach."

Even though R1 had fallen from bed 13 times, there was no comprehensive assessment to determine the reason R1 was falling from bed, any pattern in time of day or situation, or to determine why the current interventions were not working to prevent further falls.

R1's progress note dated 9/10/20, included, "Monitor right index finger related to a fall." "Nail bed and part of finger appears black."

R1's progress note dated 9//13/20, identified to,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

"Monitor right index finger related to a fall." "Patients finger continues to be black around the nail bed no redness or warmth noted to site. Nail remains intact at this time."

R1's Incident Review and Analysis report dated 9/15/20, identified R1 had fallen from her wheelchair on 9/15/20. No assessment of the cause of R1's fall from the chair was completed. The form identified R1 was sent to the emergency room for evaluation due to a head wound.

R1's hospital Admission History and Physical dated 9/15/20, included, "Patient was found on floor in bedroom and then seemed to throw herself on floor at nursing station. She has been agitated/verbally upset at times. Wanting to go upstairs." The results from a CT of head noted an acute nondisplaced fracture of the left posterial parietal bone (skull fracture). R1's hospital discharge summary identified R1 had sustained a closed skull fracture and a fracture of her right hand 2nd finger which would be splinted before returning to the nursing home. The finger fracture was in a stage of healing, identifying it had happened in the past. The facility identified an injury to R1's right index finger in the the progress notes on 8/30/20. However, this was not assessed by a physician or x-rayed until hospitalized on 9/15/20.

When interviewed on 9/24/20, at 1:00 p.m. NA-B stated R1 had fallen from bed a lot and from her wheel chair, she was constantly trying to stand up and required one on one attention or she would fall. NA-B stated they did not have time to do one on ones with R1. NA-B did not know of any interventions that helped R1 with the agitation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

and trying to stand up all the time, other than to sit with her one on one, winch was not possible as other residents required care too.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated R1 had fallen frequently, she would scream and throw herself from bed. The only interventions she knew of was to have the bed in the low position and mats on the floor so when R1 did this she wouldn't be injured. NA-C remembered R1 had a large swollen egg sized area on her forehead and had broken her finger, but did not know when this occurred.

When interviewed on 9/24/20, at 3:07 p.m. R1's guardian stated they were concerned about R1 sustaining a fractured finger that went undiagnosed for so long.

When interviewed on 9/24/20, at 3:45 p.m. licensed practical nurse (LPN)-B stated R1 was constantly throwing herself off the bed and threatening to throw herself off the bed. There was not enough staff to do one on ones and supervision with R1. LPN-A was unable to find any assessment of R1's falls for pattern or to determine why she was falling. LPN-A stated it was R1's behaviors, but was unable to find any assessment of R1's behaviors to determine why she was, "throwing herself," out of bed.

When interviewed on 9/28/20, at 10:10 a.m. the director of nursing (DON) stated they did not have a good system for when someone falls and they are trying to improve this process. The nurse should fill out an Incident Review and Analysis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21 after each fall. The DON was only able to find 4 of these for R1's falls, which were for the falls sustained on 7/14/20, 7/31/20, 8/1/20, and 9/15/20. The DON did not know why this assessment had not been filled out for any of the other falls R1 sustained. R1 had behavioral issues and really required one on one attention, which they were unable to provided. The DON was unable to provide any assessment to determine if there was a pattern to R1's falls, and what interventions may assist R1 with her anxiety/behaviors that led to her falling so frequently. No assessment had been completed of R1's behaviors to determine interventions that may help. R4's significant change MDS dated 8/27/20, included severe cognitive impairment with a diagnosis of dementia with behavioral disturbance. R4 required extensive assist for bed mobility and dressing and total staff assistance for transfer, toileting, and personal hygiene. R4 was totally incontinent of bladder and rejected cares 1-3 times during the assessment period. R3 had 1 fall without injury since prior assessment. R4's fall CAA included, "Resident triggers for falls r/t having impaired balance, history of falls, and psychotropic medication use. Resident has declined in both mobility and cognitive functions. She has recently enrolled in hospice for end of life cares. Has increased risk of falls r/t daily use	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

of hypoglycemic, antihypertensive, diuretic, narcotic, and psychotropic medications. She is incontinent of bowel and bladder. She has had a recent fall from bed. Plan to continue to monitor for safety and keep call light within reach."

R4's care plan dated 6/26/20 indicated, "Fall risk related to [blank]. Staff were directed, "Bed in lowest position. Call light within reach; fall mat. Follow PT and OT instruction for mobility function." The most recent intervention, "Ambulate to dining room with FWW [front wheel walker] support with CGA [contact guard assist] 120 ft [feet] x1 [with 1 staff] with FWW support" was added 7/22/20. No additional updates had been made.

R4's nursing assistant Care Sheet included, "Assist of 2 w/ [with] Hoyer [mechanical lift]; Does not ambulate; fall mat; call light within reach."

R4's progress note dated 8/26/20, at 10:51 p.m. included, "At 7:35 pm nurse aide found resident lying on floor next to bed. Resident appeared agitated/anxious and continued to try and stand/yell at staff. Resident swinging arms at staff when trying to position Hoyer [mechanical lift] sling so resident assisted back up into bed with Ax2 [assist of 2 staff]. Call light was within reach; fall mat was in place next to bed; bed was in lowest position; room was clear of clutter and well lit." "Resident received PRN [as needed] Seroquel [antipsychotic] for increased agitation/anxiety and was asleep within the following hour. Hospice, ADON [assistant director of nursing], and emergency contact were all notified. Writer and emergency contact talked about in-facility family visits in hospices [sic] to ease resident's anxiety/agitation and emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23	F 689		

contact thought it would be worth a try; Emergency contact is going to try and stop for a visit tomorrow."

When interviewed on 9/28/20, at 10:00 a.m. registered nurse (RN)-A stated there was no incident report or post fall follow-up report on R4's fall. R4's care plan was incorrect about walking R4, as she is no longer able to ambulate.

When interviewed on 9/28/20, at 11:35 a.m. family member (FM)-B stated they had not been allowed to visit related to COVID and was concerned about R4's falls. FM-B stated R4 would not be able to see them out her window for a visit. No one had spoken to them about possibly visiting to decrease anxiety.

When interviewed on 9/28/20, at 12:35 p.m. LPN-D stated R4 had fallen a couple times, rolling from bed. They put a mat on the floor next to the bed and make sure R4 has her call light in reach. LPN-D stated R4 would not know how to use the call light and was unsure why that was an intervention.

When interviewed on 9/28/20, at 3:05 p.m. RN-A stated, R4 was to have increased family window visits after this fall to aide in preventing more falls. The DON stated, the interdisciplinary team should meet after each fall, update care sheets and care plan, and communicate the change, but the increased family visits had not been communicated to the family or added to R4's care plan. The facility was behind in updating care plans.

R3's admission MDS dated 8/15/20, included moderate cognitive impairment with diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 risk 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25	F 689		

and free from falls." Staff were directed to, Answer call light promptly, use a mechanical lift for transfers, follow therapy instructions, call light in reach, proper footwear, ensue frequently used items were in reach.

R3's progress note dated 8/10/20, at 9:31 p.m. included, "Writer was called into room when aid walked in and saw resident laying prone on the floor. Resident was next to wheelchair and was eating supper. Aid, ADON and writer helped resident up using hoyer [mechanical] lift. Resident states that he was eating and his spoon dropped and he went to go catch it and fell out of his wheelchair. Resident states he hit his nose on the chair that was next to the wheel chair."

R3's progress note dated 8/22/20, at 6:55 p.m. included, "Residents door was open and writer was at the medicine cart adjacent to the room." "Pt [patient] was attempting at self transfers and RN heard some sound that was apparently from his wheel chair and no sooner than he turned, he saw the resident fall to the floor."

R3's progress note dated 8/28/20, included, "Writer was called by aid to assist resident off the floor. Resident was on the ground on his bottom and had his hands holding onto side rail of bed. Resident was sitting crossed legged next to bed sitting up. Resident states he was getting out of his wheel chair to get into bed. Resident then slipped off the bed and onto his bottom next to bed. Resident's vital signs were within normal limits. Resident was reminded to use his call light for all transfers."

R3's progress note dated 9/4/20, 10:32 p.m. included, R3 self transferred and was found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26 sliding off edge of bed. R3's progress note dated 9/11/20, included, "Resident was laying on back on the ground. Resident was holding handle gripper in hand and waiving it in the air. Residents wheelchair was right next to him with the breaks unlocked. Resident states he was chasing the cats out of his room and using the handle gripper to get them out of his way. Resident then fell out of wheelchair while doing this." "Resident was told there were no cats in this facility." There was no assessment of R3's belief there were cats in his room, even though R3 had not had hallucinations or delusions at the time of the comprehensive assessment. When interviewed on 9/28/20, at 10:31 a.m. LPN-C stated other than what was already in the care plan, no new interventions were added after any of these falls. LPN-C was unable to provide any post fall assessment for any of these falls. The facility had not assessed each fall to determine root cause, nor place interventions to prevent the falls from happening again. R3 had increased confusion after admission, which was not assessed other than to offer psych services, which the family declined. Normally, the interdisciplinary team would assess each fall the next day and place new interventions based upon that assessment, but this had not been done for R3. When interviewed on 9/28/20, at 11:44 a.m. the 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	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27	F 689		

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 prevent serious injury from falls. 6. Care plans will be updated to reflect fall interventions."

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.

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 consistency, small bites thorough mastication (chewing), swallow bites before taking another bite/sip, slow pacing, single sips, alternate between liquids/solids. The report indicated further analysis would be required to determine if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28	F 689		

R10 would be appropriate 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.

R10's care plan dated 4/1/20, included, risk for nutritional alteration related to coughing during meals; had diet restrictions which included NDD2 [National Dysphagia Diet, level 2- meats are to be ground or are minced no larger than 1/4 inch pieces, they are moist, with some cohesion] diet and could have requested puree. Staff were directed to monitor, document, and report to the physician as needed for signs and symptoms of swallowing problems.

R10's undated nursing assistant Care Guide included mechanical soft diet with pureed meat.

R10's Nutrition Evaluation dated 4/16/20, identified a mechanical soft diet with pureed meat. Speech therapy recommended to, "have all meats ground, unless resident request pureed for preference."

R10's Oral/Dental Evaluation dated 7/14/20, indicated R10 had full upper and lower dentures.

During observation on 9/25/20, at 12:42 p.m. R10 was observed to be coughing while eating. At 12:47 p.m. it was noted R10 was eating a regular hamburger patty on a bun. R10 stated it was hard to eat because she did not have her dentures in. She had requested the regular patty as the staff had grilled out the burgers and she desired one. R10 continued to cough while eating, no one checked to see if she was alright,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29	F 689		

nor did anyone bring her dentures.

R10's lunch tray ticket included, "Mechanical soft texture and to provide ground grilled hamburger, potato salad, no raw veggies, beans, shredded lettuce."

When interviewed on 9/25/20, at 1:06 p.m. dietary aide (DA)-A stated residents who require a mechanical soft diet should have been provided with ground meat. R10 coughing is something she normally does while eating.

When interviewed on 9/25/20, at 1:12 p.m. cook (CK)-A stated, a mechanical soft diet should have ground meat, no bread or hard vegetables. The cook is the person responsible to ensure the correct diet is served.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated R10 does cough at meals, she was unaware R10 did not have dentures in. NA-F stated if someone is coughing like that, they should go get a nurse to assess if no nurse was in the dining room.

When interviewed on 9/25/20, at 1:34 p.m. R10 stated she normally gets a ground burger, but today got a regular whole burger as they were grilling them. R10 stated she normally wore her dentures, but forgot them today. Staff sometimes have to remind her to put them in or help her with them. At 1:39 p.m. R10 was coughing and NA-H asked her if she was ok.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated resident's diets could be upgraded if they wished for an upgrade, but would have to sign a risk versus benefits statement. R10 did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30	F 689		

a risk versus benefits statement signed nor was she given the risks of choking when provided with a regular hamburger today.

When interviewed on 9/25/20, at 3:08 p.m. Cook-A stated they have a file of each resident who had signed a risk versus benefits statement for a diet upgrade, then if they ask for an upgrade they can provide it. R10 did not have one of these. R10 should have been provided the ground meat diet as ordered and not a regular hamburger.

R10's Diet Requisition Form provided by Cook-A and dated 3/31/20, had been completed by speech therapy and indicated R10 was to have a Mechanical Soft/Ground Meat NDD2 diet consistency and patient could downgrade to pureed food if desired.

When interviewed on 9/28/20, at 10:21 p.m. the registered dietician (RD) stated if a resident were coughing during a meal it should be reported to the DON, food service director and speech therapy. This had not been done for R10. The facility should not provide an upgraded texture diet without risks being explained to the resident and a form signed.

When interviewed on 9/28/20, at 2:37 p.m. the DON and RN-A stated it is important to provide the correct diet texture for residents with swallowing problems. A nurse should be notified if a resident is coughing.

R5's quarterly MDS dated 9/4/20, indicated no cognitive impairment with diagnoses including, stroke, epilepsy. The MDS noted R5 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 31	F 689		

coughing and choking during meals or when swallowing medications during the assessment period. The MDS further indicated supervision, oversite, set up when eating and mechanically altered textures.

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.

R5's Care Assessment Area Worksheet (CAA) dated 1/20/20, indicated R5 required a mechanically altered diet. There was no analysis completed, but was noted to proceed to care planning.

R5's care plan dated 3/20/20, indicated R5 was at risk for nutritional alteration related to chronic pain front thorax and diet restriction for NDD3 diet. Staff were directed to monitor, document and report to physician for signs or symptoms of dysphagia when eating.

R5's Progress note dated, 1/25/19, indicated her diet was changed to NDD3 by Speech therapy.

R5's Nutritional Evaluation dated 9/4/20, identified a diet order for NDD3, Dysphagia Advanced diet level 3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32	F 689		

R5's Care guide for staff indicated a regular diet and independent in dining room which is different from MDS 9/4/20, CAA 1/20/20, Medical Record, physician order and care plan.

R5's lunch tray ticket included a diet order for Dysphagia Advanced diet (NDD3). The tray ticket further directed to provide chopped, grilled hamburger on bun, potato salad, no raw vegetables, backed beans, no bacon, shredded lettuce, soft ice cream and milk.

During an observation on 9/25/20, at 12:50 p.m. R5 sat alone at a table and was noted to cough while she ate her meal. R5's plate contained a whole hamburger with a wedge of lettuce that covered the burger on a bun and potato chips. There were various staff throughout the dining area including nursing and dietary, but no one stopped to see why R5 was coughing. At 12:52 p.m. R5 was observed to be shaking and asked for someone get a nurse because she was having a seizure. Staff came and brought R5 out of the dining room.

When interviewed on 9/25/20, at 1:06 p.m. DA-A stated R5 should have received ground meat, beans, potato salad, soft cooked vegetables. R5 should not have had a bun, the burger should have been ground and should not have received potato chips or whole leaf lettuce.

When interviewed on 9/25/20, at 1:10 p.m. R5 stated she has occasional seizure that are like, "spells," and has no diet restrictions.

When interviewed on 9/25/20, at 1:12 p.m. Cook-A stated the facility provided NDD3, NDD2 and pureed textures. A mechanical diet should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33	F 689		

have ground meat, no bread or hard vegetables. For the noon meal provided on 9/25/20, a mechanical texture should have included, no bun, ground hamburger, potato salad and beans. It was the cook's responsibility to make sure a resident is getting the appropriate texture.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated staff should check on residents who are coughing and should get a nurse. R5 should have received the correct diet and did not know who gave her the wrong diet.

When interviewed on 9/25/20, at 1:40 p.m. Dietary Aide-A reported both dietary and nursing aides deliver meal trays.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated a resident is ok to be provided an upgraded texture if a risk and benefit form had been signed. The resident should be given the order from the physician if there is no signed risk and benefit form. R5 did not have a signed form.

On 9/25/20 at 3:08 p.m. Cook-A- stated R5 should have received the ordered diet, but did not, the Cook is responsible for providing the correct diet.

The facility Refusal of Care/Interventions, Risk and Benefits policy dated 9/11, identified a resident would be informed of the risk and benefits of necessary care and given the opportunity regarding their decision in the plan of care. The resident would be approached 2-3 times and if resident continued to refuse, documentation should be made on the Refusal of Care Interventions Risk and Benefits and reviewed quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	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 soft, well-cooked vegetables. Vegetables should be less than 1/2 inch and should be easily mashed with a fork.	F 689		
F 725 SS=F	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 at §483.70(e). §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: (i) Except when waived under paragraph (e) of	F 725		11/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 35 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide for the individualized care planned needs for 8 of 8 residents (R5, R7, R4, R1, R3, R8, R13 and R12), 12 of 15 staff (LPN-B, LPN-A, LPN-D, NA-D, NA-C, NA-J, NA-B, NA-F, NA-A, RN-A, HSK-A and NA-C) and 1 of 3 family members (FM)-A, reviewed for sufficient staffing. This had the potential to affect all 42 current residents. Findings include: R5's quarterly Minimum Data Set dated 9/4/20, included cognitively intact with diagnoses of stroke with paralysis or weakness on one side of the body and a seizure disorder. R5 required physical assistance from staff for toileting and bathing. R5 Care Assessment Worksheet (CAA) dated 1/20/20, included, R5 extensive assistance with activities of daily living (ADL) including bathing and toileting. R5's care plan updated 8/12/20, included, R5 needed assistance with toilet use and shower/bath with one assist twice a week on Sunday and Wednesday evenings with skin	F 725	F725=F. Based on observation, interview, and document review, the facility failed to ensure sufficient staff to provide for the individualized care planned needs for 8 of 8 residents, 12 of 15 staff, and 1 of 3 family members, reviewed for sufficient staff. This has the potential to affect all 42 current residents. Pleasant Manor has the responsibility to provide services by sufficient numbers to promote resident rights and dignity. The policy in regards to completing a Facility Assessment has been reviewed and remains appropriate. The facility completed a facility assessment to assess and identify appropriate staffing needs for the current level of care and provide guidance for future staffing needs for the appropriate level of care. Daily staffing assignments will be signed off by Administrator or Director of Nursing daily. Education will be completed with IDT through QAPI and with facility staff through an all-staff meeting regarding executed facility assessment and daily review of staffing. Administrator or designee will perform audits weekly x 4 weeks, monthly x 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 not getting the timely care she needed with toileting, bathing and hygiene as there was not enough staff. R5 did complain about this. 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. When interviewed on 9/24/20, at 3:22 p.m. a nursing assistant (NA)-D stated R5 required assistance with bathing and toileting, but often she had to wait for assistance as they do not have enough staff to get to everyone timely. Sometimes they have to skip R5's bath as they do not have enough 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. R5's Grievance/Concern Report included, R5 did not receive a bath or shower on 7/22/20. NA-I stated, "R5's shower did not get done on Sunday evening due to time." NA-J stated, "R5's shower did not get done due to running out of time. Her bath requires two aids which [NA-I] and I were the	F 725	months, and quarterly thereafter to ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed: 11/2/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 37	F 725		

only two on the floor until 6 p.m. After 6 we still had a lot to do and ended up not having enough time to get in the bath R5 wanted. There was also another shower that was supposed to get done that we never got done."

Shower/bath records dated July to September 2020: R5 received a shower on 7/19 but not again until 8/17/20, and then not again until 8/24//20. R5 received a bath on 9/13/20, but not again until 9/21/20.

Review of R5's call light log from 9/1/20 (6:53 p.m.) to 9/29/20 (2:24 p.m.), indicated, R5 used the call light 166 times. Of the 166 instances, the wait time was over 20 minutes on 69 occasions or 41.5% of the time.

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.

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.

R7's care plan dated 7/29/20, included, R7 required assistance for, "Bathing with max to dependent assist, dressing with max assist, personal hygiene set-up with minimal assist, occasionally incontinent, and requires assistance with toilet use."

When interviewed on 9/24/20, at 1:31 p.m. a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 38	F 725		

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 night shift is customarily staffed with two NA's and 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 the individual needs of each resident. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 39	F 725		

morale among staff and residents is low because of this.

R7's call light response time logs dated from 9/22/20, at 3:51 a.m. to 9/28/20, 9:25 a.m. showed the call light was engaged 51 times over the seven day period. Of the 51 call light alerts initiated, 11 (or 21.5%) of these alerts took over 15 minutes to receive a response. Seven (or 14%) of these alerts took longer than 20 minutes to receive a response.

R4's admission Minimum Data Set (MDS) dated 6/29/20, included, moderate cognitive impairment with diagnoses including diabetes, dementia and arthritis. R4 required extensive assistance with toileting and limited assistance with personal hygiene. R4 was not on a toileting program and was occasionally incontinent of urine (less than 7 times during the assessment period).

R4's incontinence Care Area Assessment (CAA) dated 7/1/20 indicated, "Resident triggers for urinary incontinence r/t [related to] need for assistance with toilet use and bladder incontinence." "She is in PT [physical therapy] and OT [occupational therapy] at this time with the goal of returning to the community. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's significant change MDS dated 8/27/20, included severe cognitive impairment, was totally dependent upon staff for toileting and personal hygiene and was always incontinent of urine.

R4's incontinence CAA dated 8/28/20 included,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 40	F 725		

"Resident triggers for urinary incontinence r/t toilet use and bladder incontinence. Resident has declined in both mobility and cognitive function. She has recently enrolled in hospice for end of life cares. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's only Bowel and Bladder assessment in the medical record was dated 6/24/20, and indicated R4 was continent of bowel and bladder.

R4's care plan dated 6/26/20, included, "Alteration with elimination." Staff were directed to, "Assist of 1 with toileting." The care plan had not been updated since 6/26/20, even though the 8/27/20, MDS noted a decline in urinary incontinence to totally incontinent and an increase in assistance needs for toileting and personal hygiene.

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.

During continuous observation on 9/25/20, starting at 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to provide incontinence cares occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. LPN-D then brought R4 to the dining room. Incontinence cares were not provided. At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 41 1:58 p.m. NA-F and NA-B assisted R4 into bed and changed R4's visibly wet brief. 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 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 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. R4's call light log from 9/1/20 - 9/29/20 revealed R4 used the call light 20 times. Of the 20 instances the wait time was over 10 minutes on five occasions, over 40 minutes on one occasion, and over 60 minutes one occasion.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 42	F 725		

R1's quarterly Minimum Data Set (MDS) dated 8/20/20, included, severe cognitive impairment with diagnoses including TBI (traumatic brain injury) and dementia. R1 required extensive assistance with most activities of daily living (ADL's) and did not ambulate. R1 had 2 or more falls with injury since the prior assessment. R1 had a discharge MDS dated 9/16/20.

R1's care plan dated 9/2/20, included, "Fall risk AEB [as evidenced by] multiple falls since admission related to lack of safety awareness secondary to TBI and Dementia with behavioral disturbances." The goal for R1 was listed as, "Resident will be safe and free from serious injury should incident occur." Staff were directed to, "Provide one on one care, such as taking outside and wheeling her down the hall."

The facility provided a running list of R1's falls from 7/21/20 thorough 9/24/20, which indicated R1 had fallen in the facility 17 times in that time frame. 7/14/20, 7/31/20, 8/1/20, 8/5/20, 8/6/20, 8/11/20, 8/12/20, 8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20, 8/21/20, 8/29/20, 9/3/20, 9/14/20 and 9/15/20.

Hospital discharge summary dated 9/16/20, indicated R1 was transferred to the hospital on 9/15/20 after sustaining a fall related to increased agitation. Summary details R1 incurred a fractured skull and finger.

R1's progress notes from 9/16/20 to 9/21/20, revealed:
-9/16/20, at 4:36 p.m. R1 returned to the facility from the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 43	F 725		

R1's progress note dated 9/16/20, at 5:35 p.m. included R1 had attempted to crawl out of bed several times after returning from the hospital. Facility transferred R1 to her wheelchair, R1 then started to yell out and reported of pain in neck and back. R1 reported to facility of pain in her neck and back. R1 started to stand up from her wheelchair. Facility initiated a 2 to 1 staff to R1 ratio as the facility determined R1 was not safe. R1's physician was contacted and consulted and confirmed for the R1 to be sent back to the hospital. R1's guardian was informed of the transfer situation.

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.

R1's progress noted dated 9/16/20, at 6:28 p.m. included, R1 was noted to have continued marked behaviors: swore at staff, attempted to put herself onto the floor, yelling and hollering louder than her usual, R1 was extremely agitated and 1:1, 2:2, 3:3 were attempted and R1 remained aggressive towards staff. Facility called 911 to send R1 to emergency department (ED) for further evaluation per physician's orders.

When interviewed on 9/24/20, at 1:00 p.m. NA-B stated there were times when R1 required one on one attention, but they only had one or two staff to cover a unit of 30 residents, so this was not possible.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated they did not have enough help to watch R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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F 725	Continued From page 44 all the time and she fell a lot. When interviewed on 9/24/20, at 2:56 p.m. the emergency room social worker stated the facility would not take R1 back to the facility because they did not have enough help to watch her well enough. When interviewed on 9/24/20, at 3:22 p.m. NA-D stated R1 required a significant amount of staff time to prevent her from falling and they just did not have the time to stay with her all the time. NA-D stated she worked the day shift and often when arriving for her shift would find R1, "sopping wet," in her incontinent brief. When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated there was not enough staffing to supervise R1 and keep her safe as she required individual attention. When interviewed on 9/28/20, at 10:10 a.m. the DON stated due to limited staffing R1's needs could not be met at the facility, therefore R1 could not be readmitted after her last admission to the hospital. R3's admission minimum data set (MDS), dated 8/15/20, revealed R3 had moderate cognitive impairment. R3 required supervision and one staff physical assistance for eating. R1's diagnosis included a stroke. R3 had the following swallowing concerns: loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, and coughing during meals or when	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

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F 725	Continued From page 45 swallowing medications. R3's care plan, last updated 9/24/20, directed staff, "The resident needs a calm, quiet meal time with adequate eating time. The resident requires all meals in the dining room r/t [related to] close supervision-not to receive meals until supervision is provided." When interviewed on 9/24/20, at 12:56 p.m. NA-A stated she worked day shift and considered it, "understaffed." NA-A reported residents waited to be provided morning cares prior to breakfast, especially if they required two staff and assistance with mechanical lift. NA-A stated, R3 required individual assistance for cueing him to not eat too quickly or take too big of a bite and to get enough fluid. NA-A noted R3 often had to wait over 40 minutes to eat until they had enough staff in the dining room to help him. When interviewed on 9/24/20, at 3:22 p.m. NA-D stated, R3 required staff to closely monitor to make sure he ate the amount he should. Often no staff were available to help, he would sit and look around the room, waiting for his plate of food. When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated, there were several residents that required assistance in the dining room and it was difficult to figure out how to feed R3. R3 required help the entire time due to choking precautions and required assistance the entire meal time. During observation on 9/25/20, at 12:21 p.m. R3 wheeled self into the dining room. R3 rolled his wheel chair back and forth at the table, looking around until his meal was brought to him at 12:41 p.m.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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F 725	Continued From page 46	F 725		

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated there is never enough staff in the dining room to feed everyone. "On a good day, we are lucky to have 2 aides to assist all the residents."

R8's admission MDS, dated 8/10/20, included, R8 was cognitively intact with a diagnosis of Parkinson's disease. R8 required physical assistance of 2 staff for transfers and supervision and one person physical assistance for toileting.

R8's care plan, last revised 8/24/20, directed staff, "Alteration in elimination r/t [related to] Parkinson's" and, "Assist of 1 with toileting as needed for hygiene."

When interviewed on 9/24/20, at 12:23 p.m. 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.

When interviewed on 9/28/20, at 10:37 a.m. R8 stated there was not enough staff to help her when she needed it. R8 stated she has problems with stiffness and decreased ability to do things on her own when her Parkinson's medication was late. R8 stated staff tell her they have a half hour

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

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F 725	Continued From page 47	F 725		

on each side of the time her medication is due, but it is often over that. R8 stated staff tell her they do not have enough staff to get it to her on time. R8 stated she does not get enough help to the bathroom, she often has to wait 20-40 minutes to get on or off the toilet. This causes her back to hurt and she gets even more still and unable to care for herself even more.

R8's medication administration record (MAR), dated August 2020, included an order for Carbidopa-Levodopa (a medication for treating Parkinson's disease symptoms such as muscle stiffness, tremors, spasms, and poor muscle control) five times daily; 5:55 a.m., 10:00 a.m., 4:00 p.m., 7:30 p.m. and 11:30 p.m. R8 was noted as being administered the medications at each opportunity, but the time administered was not noted.

When interviewed on 9/28/20, at 10:58 a.m. LPN-D stated R8 wanted her medications on time. LPN-D stated R8 reported concerns with getting her medications on time in the evening.

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.

R13's care plan, dated 7/3/20, incontinence and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 48	F 725		

risk for skin breakdown and required staff assistance. The care plan indicated to keep the call light in reach and answer promptly.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated R13 was totally dependent on staff for cares. Sometimes R13 had to stay in bed for breakfast as they didn't have enough staff to get her up before breakfast. R13 would prefer to get up, but is agreeable when they need her to be. Often R13 would be, "saturated" by the time they were able to attend to her after breakfast.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated when coming on for the afternoon shift they would find R13 soaked in urine. NA-D was often the only staff on afternoons who was competent to use the mechanical lift needed to get R13 up, and due to this, often R13 had to stay in bed at supper time. This would upset R13, but they just didn't have enough help to always get her up.

When interviewed on 9/28/20, at 11:05 a.m. R13 stated she is incontinent of urine due to her 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, between 50 and 60 minutes on 5 occurrences and over 60 minutes on four occurrences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 49	F 725		

R12's quarterly MDS dated 8/14/20, included, R12 had moderate cognitive impairment. R12 was on hospice services and required oxygen care. R12's diagnoses included coronary artery disease, asthma/chronic obstructive pulmonary disease or chronic lung disease and respiratory failure.

R12's medication and treatment administration report (MAR/TAR), dated August 2020, directed staff, "Connect 02 1.5 L [liters]/min [minute] at bedtime." and "Oxygen at 1.5L/min per nasal cannula while at rest and at night. This was not marked as completed on the night of 9/4/20 and 9/17/20. The MAR/TAR directed "Ensure resident has bipap on every overnight, every night shift for cpap placement. Please ensure Cpap is in place every hour overnight." This was not marked as completed on 9/4/20 and 9/17/20. and "Bipap-Nurse must put on use daily when sleeping and at night." This was not marked as completed the night of 9/4/20 and 9/17/20.

On 9/24/20, at 3:45 p.m. LPN-B stated, R12's and family had concerns about staffing. LPN-B R12 was, "slower," and "needier," than other residents.

On 9/25/20 at 10:39 a.m. a family member of R12, (FM)-A stated she monitored R12's care through video. R12 wore a bipap mask at night and oxygen nasal cannula during the day to assist with respiratory and breathing issues. FM-A would notice times R12's bipap or oxygen was not applied, or not applied properly for significant amounts of time, noting recent example between 3:20 a.m. to 3:50 a.m.; 5:00 a.m. to 7:10 a.m., and 10:10 p.m. to 1:17 a.m. on 9/24/20. FM-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 50	F 725		

reported, during these instances, she would call the facility to alert staff, without response. During the interview, R12 noted she did not feel well when she was not getting the oxygen she needed, like she was in a "daze". FM-A reported R12 was deteriorating both cognitively and physically and was more confused when not on the oxygen. FM-A stated, on 9/18/20 to 9/19/20 she noted no camera activity, indicating no movement detected, in R12's room between 11:34 p.m. and 4:09 p.m. FM-A noted R12 required frequent monitoring to ensure her bipap was on properly. FM-A reported R12 had told her she felt like a burden to staff. FM-A reported she had informed the director of nursing of her concerns and there was no resolution or improvement.

R12's call light log, dated 9/1/20 to 9/29/20, included, R12 activated the call light 66 times. Eleven of those were answered in 10 to 20 minutes. Six were answered between 20 to 30 minutes. Six were answered between 30 to 40 minutes. One was answered between 40 and 50 minutes. Six were answered in over 60 minutes

When interviewed on 9/24/20, at 12:23 p.m. LPN-A stated there were not enough staff to care for residents. LPN-A explained there were sometimes only one aide on west side of the care center. Residents were not getting the timely care they needed with timely toileting, bathing and hygiene. The workload was stressful and contributing to staff burnout and turnover. LPN-A stated, she had discussed concerns with DON and administrator and there had been no resolution. LPN-A reported she helped the nursing assistants with cares when she was able but was busy with completing treatments and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 51	F 725		

medication pass for residents. LPN-A reported there was an overall concern with resident not getting the timely assistance with bathing and hygiene.

When interviewed on 9/24/20, at 1:31 p.m. NA-C reported she was pulled away from her nursing assistant duties to help with electronic medical appointments and wound rounds. There was not sufficient nursing staff to provide oral care and peri-cares for residents. The nurses were too busy with their own duties to assist. Most of the time baths and showers were missed and residents were not assisted with morning and evening cares when they preferred. Staff would chart a resident refused a bath, when the resident had not been offered, or chart a resident was bathed, when they were not bathed. This had been reported to both the DON and administrator with no changes.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated she worked the night shift and there were times when she would be the only nurse aid in the building. Resident call lights were on for extended periods of time- sometimes over an hour. They just could not get to them timely. At meal times residents complain of cold food. "Short staffing is a daily occurrence." This had been reported to the administrator but was told there was nothing they could do about it.

When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated there was one or two aides for 30 residents. Nurses were expected to provide personal cares for 5 residents each shift in addition to their regular duties. Sometimes, they were not able to make sure resident treatments were completed. When staff come from a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 52	F 725		

staffing agency, they are reluctant to return as they do not have enough time to complete all of their work. LPN-B had reported this concern to management and was told they had enough staff.

When interviewed on 9/25/20, at 11:12 p.m. HSK-A stated nursing assistance seem to be, "burned out," because they do not have enough time to meet resident needs.

When interviewed on 9/28/20, at 3:36 p.m. the administrator, assistant administrator, DON and RN-A were interviewed together. There was no facility assessment to determine the specific staffing needs to meet resident care planned needs. Typically, there should be 1 nursing assistant per 10 residents. DON stated there were residents who complained about call light wait times, particularly at night time. RN-A stated, "The staff have made it seem so drastic" but noticed "a lot of standing around." The administrator noted she was working on team dynamics and culture change in response to staffing concerns. The administrator reported she was committed to improving the staffing situation and chipping in within her abilities. DON reported she felt there was an adequate number of staff but felt the communication was poor. DON reported there was a situation where there was too many staff and less work got done. RN-A reported there was fewer staff because the census was down.

The facility staffing policy, dated 10/17, directed staff, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care ad services for all residents in accordance with resident care plans and assessment." and "Staffing numbers and the skill

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 53 requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care."	F 725		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prepare food in accordance with residents needs for 2 of 3 residents (R5 and R10) reviewed who required modified texture diets. Findings include: 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. 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 consistency, small bites thorough mastication (chewing), swallow bites before taking another bite/sip, slow pacing, single sips, alternate between liquids/solids. The report indicated further analysis would be required to determine if	F 805	F805=D. Based on observation, interview, and document review, the facility failed to prepare food in accordance with residents needs for 2 of 3 residents reviewed and required modified texture diets. Pleasant Manor residents have the right to receive food prepared in a form designed 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. The associated policies related to serving 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 diet textures during meal time. Culinary Director/Dietitian or designee will perform audits weekly x 4 weeks, monthly x 3 months, and quarterly thereafter to	11/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 805	Continued From page 54 R10 would be appropriate 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. R10's care plan dated 4/1/20, included, risk for nutritional alteration related to coughing during meals; had diet restrictions which included NDD2 [National Dysphagia Diet, level 2- meats are to be ground or are minced no larger than 1/4 inch pieces, they are moist, with some cohesion] diet and could have requested puree. Staff were directed to monitor, document, and report to the physician as needed for signs and symptoms of swallowing problems. R10's undated nursing assistant Care Guide included mechanical soft diet with pureed meat. R10's Nutrition Evaluation dated 4/16/20, identified a mechanical soft diet with pureed meat. Speech therapy recommended to, "have all meats ground, unless resident request pureed for preference." R10's Oral/Dental Evaluation dated 7/14/20, indicated R10 had full upper and lower dentures. During observation on 9/25/20, at 12:42 p.m. R10 was observed to be coughing while eating. At 12:47 p.m. it was noted R10 was eating a regular hamburger patty on a bun. R10 stated it was hard to eat because she did not have her dentures in. She had requested the regular patty as the staff had grilled out the burgers and she desired one. R10 continued to cough while eating, no one checked to see if she was alright,	F 805	ensure compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 11/2/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

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F 805	Continued From page 55	F 805		

nor did anyone bring her dentures.

R10's lunch tray ticket included, "Mechanical soft texture and to provide ground grilled hamburger, potato salad, no raw veggies, beans, shredded lettuce."

When interviewed on 9/25/20, at 1:06 p.m. dietary aide (DA)-A stated residents who require a mechanical soft diet should have been provided with ground meat. R10 coughing is something she normally does while eating.

When interviewed on 9/25/20, at 1:12 p.m. cook (CK)-A stated, a mechanical soft diet should have ground meat, no bread or hard vegetables. The cook is the person responsible to ensure the correct diet is served.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated R10 does cough at meals, she was unaware R10 did not have dentures in. NA-F stated if someone is coughing like that, they should go get a nurse to assess if no nurse was in the dining room.

When interviewed on 9/25/20, at 1:34 p.m. R10 stated she normally gets a ground burger, but today got a regular whole burger as they were grilling them. R10 stated she normally wore her dentures, but forgot them today. Staff sometimes have to remind her to put them in or help her with them. At 1:39 p.m. R10 was coughing and NA-H asked her if she was ok.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated resident's diets could be upgraded if they wished for an upgrade, but would have to sign a risk versus benefits statement. R10 did not have

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F 805	Continued From page 56	F 805		

a risk versus benefits statement signed nor was she given the risks of choking when provided with a regular hamburger today.

When interviewed on 9/25/20, at 3:08 p.m. Cook-A stated they have a file of each resident who had signed a risk versus benefits statement for a diet upgrade, then if they ask for an upgrade they can provide it. R10 did not have one of these. R10 should have been provided the ground meat diet as ordered and not a regular hamburger.

R10's Diet Requisition Form provided by Cook-A and dated 3/31/20, had been completed by speech therapy and indicated R10 was to have a Mechanical Soft/Ground Meat NDD2 diet consistency and patient could downgrade to pureed food if desired.

When interviewed on 9/28/20, at 10:21 p.m. the registered dietician (RD) stated if a resident were coughing during a meal it should be reported to the DON, food service director and speech therapy. This had not been done for R10. The facility should not provide an upgraded texture diet without risks being explained to the resident and a form signed.

When interviewed on 9/28/20, at 2:37 p.m. the DON and RN-A stated it is important to provide the correct diet texture for residents with swallowing problems. A nurse should be notified if a resident is coughing.

R5's quarterly MDS dated 9/4/20, indicated no cognitive impairment with diagnoses including, stroke, epilepsy. The MDS noted R5 had

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F 805	Continued From page 57	F 805		

coughing and choking during meals or when swallowing medications during the assessment period. The MDS further indicated supervision, oversite, set up when eating and mechanically altered textures.

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.

R5's Care Assessment Area Worksheet (CAA) dated 1/20/20, indicated R5 required a mechanically altered diet. There was no analysis completed, but was noted to proceed to care planning.

R5's care plan dated 3/20/20, indicated R5 was at risk for nutritional alteration related to chronic pain front thorax and diet restriction for NDD3 diet. Staff were directed to monitor, document and report to physician for signs or symptoms of dysphagia when eating.

R5's Progress note dated, 1/25/19, indicated her diet was changed to NDD3 by Speech therapy.

R5's Nutritional Evaluation dated 9/4/20, identified a diet order for NDD3, Dysphagia Advanced diet level 3.

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F 805	Continued From page 58	F 805		

R5's Care guide for staff indicated a regular diet and independent in dining room which is different from MDS 9/4/20, CAA 1/20/20, Medical Record, physician order and care plan.

R5's lunch tray ticket included a diet order for Dysphagia Advanced diet (NDD3). The tray ticket further directed to provide chopped, grilled hamburger on bun, potato salad, no raw vegetables, backed beans, no bacon, shredded lettuce, soft ice cream and milk.

During an observation on 9/25/20, at 12:50 p.m. R5 sat alone at a table and was noted to cough while she ate her meal. R5's plate contained a whole hamburger with a wedge of lettuce that covered the burger on a bun and potato chips. There were various staff throughout the dining area including nursing and dietary, but no one stopped to see why R5 was coughing. At 12:52 p.m. R5 was observed to be shaking and asked for someone get a nurse because she was having a seizure. Staff came and brought R5 out of the dining room.

When interviewed on 9/25/20, at 1:06 p.m. DA-A stated R5 should have received ground meat, beans, potato salad, soft cooked vegetables. R5 should not have had a bun, the burger should have been ground and should not have received potato chips or whole leaf lettuce.

When interviewed on 9/25/20, at 1:10 p.m. R5 stated she has occasional seizure that are like, "spells," and has no diet restrictions.

When interviewed on 9/25/20, at 1:12 p.m. Cook-A stated the facility provided NDD3, NDD2 and pureed textures. A mechanical diet should

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F 805	Continued From page 59	F 805		

have ground meat, no bread or hard vegetables. For the noon meal provided on 9/25/20, a mechanical texture should have included, no bun, ground hamburger, potato salad and beans. It was the cook's responsibility to make sure a resident is getting the appropriate texture.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated staff should check on residents who are coughing and should get a nurse. R5 should have received the correct diet and did not know who gave her the wrong diet.

When interviewed on 9/25/20, at 1:40 p.m. Dietary Aide-A reported both dietary and nursing aides deliver meal trays.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated a resident is ok to be provided an upgraded texture if a risk and benefit form had been signed. The resident should be given the order from the physician if there is no signed risk and benefit form. R5 did not have a signed form.

On 9/25/20 at 3:08 p.m. Cook-A- stated R5 should have received the ordered diet, but did not, the Cook is responsible for providing the correct diet.

The facility Refusal of Care/Interventions, Risk and Benefits policy dated 9/11, identified a resident would be informed of the risk and benefits of necessary care and given the opportunity regarding their decision in the plan of care. The resident would be approached 2-3 times and if resident continued to refuse, documentation should be made on the Refusal of Care Interventions Risk and Benefits and reviewed quarterly.

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F 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 soft, well-cooked vegetables. Vegetables should be less than 1/2 inch and should be easily mashed with a fork.	F 805		

DEPARTMENT OF HEALTH

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,

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

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/24/20, 9/25/20 and 9/28/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED with a licensing order issued: H5090056C: MN Rule 4658.0520 Subp. 1 H5090057C MN Rule 4658.0510 Subp. 1 and MN Rule 4658.0525 Subp. 6 B H5090059C MN Rule 4658.0510 Subp. 1; MN Rule 4658.0525 Subp. 6 B.; and MN Rule 4658.0525 Subp.4 The following complaints were found to be unsubstantiated: H5090055C and H5090058C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide for the individualized care planned needs for 8 of 8 residents (R5, R7, R4, R1, R3, R8, R13 and R12), 12 of 15 staff (LPN-B, LPN-A, LPN-D, NA-D, NA-C, NA-J, NA-B, NA-F,	2 800	Area Acknowledged	11/2/20

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2 800	Continued From page 2 NA-A, RN-A, HSK-A and NA-C) and 1 of 3 family members (FM)-A, reviewed for sufficient staffing. This had the potential to affect all 42 current residents. Findings include: R5's quarterly Minimum Data Set dated 9/4/20, included cognitively intact with diagnoses of stroke with paralysis or weakness on one side of the body and a seizure disorder. R5 required physical assistance from staff for toileting and bathing. R5 Care Assessment Worksheet (CAA) dated 1/20/20, included, R5 extensive assistance with activities of daily living (ADL) including bathing and toileting. R5's care plan updated 8/12/20, included, R5 needed assistance with toilet use and shower/bath with one assist twice a week on Sunday and Wednesday evenings with skin checks. When interviewed on 9/24/20, at 12:23 p.m. licensed practical nurse (LPN)-A stated, R5 was not getting the timely care she needed with toileting, bathing and hygiene as there was not enough staff. R5 did complain about this. 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."	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 800	Continued From page 3 This was upsetting to R5. When interviewed on 9/24/20, at 3:22 p.m. a nursing assistant (NA)-D stated R5 required assistance with bathing and toileting, but often she had to wait for assistance as they do not have enough staff to get to everyone timely. Sometimes they have to skip R5's bath as they do not have enough 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. R5's Grievance/Concern Report included, R5 did not receive a bath or shower on 7/22/20. NA-I stated, "R5's shower did not get done on Sunday evening due to time." NA-J stated, "R5's shower did not get done due to running out of time. Her bath requires two aids which [NA-I] and I were the only two on the floor until 6 p.m. After 6 we still had a lot to do and ended up not having enough time to get in the bath R5 wanted. There was also another shower that was supposed to get done that we never got done." Shower/bath records dated July to September 2020: R5 received a shower on 7/19 but not again until 8/17/20, and then not again until 8/24//20. R5 received a bath on 9/13/20, but not again until 9/21/20. Review of R5's call light log from 9/1/20 (6:53 p.m.) to 9/29/20 (2:24 p.m.), indicated, R5 used the call light 166 times. Of the 166 instances, the wait time was over 20 minutes on 69 occasions or 41.5% of the time.	2 800		

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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. 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. R7's care plan dated 7/29/20, included, R7 required assistance for, "Bathing with max to dependent assist, dressing with max assist, personal hygiene set-up with minimal assist, occasionally incontinent, and requires assistance with toilet use." When interviewed on 9/24/20, at 1:31 p.m. a 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.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 800	Continued From page 5 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 and 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 the individual needs of each resident. The morale among staff and residents is low because of this. R7's call light response time logs dated from 9/22/20, at 3:51 a.m. to 9/28/20, 9:25 a.m. showed the call light was engaged 51 times over the seven day period. Of the 51 call light alerts initiated, 11 (or 21.5%) of these alerts took over 15 minutes to receive a response. Seven (or 14%) of these alerts took longer than 20 minutes to receive a response. R1's quarterly Minimum Data Set (MDS) dated 8/20/20, included, severe cognitive impairment with diagnoses including TBI (traumatic brain injury) and dementia. R1 required extensive assistance with most activities of daily living (ADL's) and did not ambulate. R1 had 2 or more falls with injury since the prior assessment. R1 had a discharge MDS dated 9/16/20.	2 800		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 800	Continued From page 6 R1's care plan dated 9/2/20, included, "Fall risk AEB [as evidenced by] multiple falls since admission related to lack of safety awareness secondary to TBI and Dementia with behavioral disturbances." The goal for R1 was listed as, "Resident will be safe and free from serious injury should incident occur." Staff were directed to, "Provide one on one care, such as taking outside and wheeling her down the hall." The facility provided a running list of R1's falls from 7/21/20 thorough 9/24/20, which indicated R1 had fallen in the facility 17 times in that time frame. 7/14/20, 7/31/20, 8/1/20, 8/5/20, 8/6/20, 8/11/20, 8/12/20, 8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20, 8/21/20, 8/29/20, 9/3/20, 9/14/20 and 9/15/20. Hospital discharge summary dated 9/16/20, indicated R1 was transferred to the hospital on 9/15/20 after sustaining a fall related to increased agitation. Summary details R1 incurred a fractured skull and finger. R1's progress notes from 9/16/20 to 9/21/20, revealed: -9/16/20, at 4:36 p.m. R1 returned to the facility from the hospital. R1's progress note dated 9/16/20, at 5:35 p.m. included R1 had attempted to crawl out of bed several times after returning from the hospital. Facility transferred R1 to her wheelchair, R1 then started to yell out and reported of pain in neck and back. R1 reported to facility of pain in her neck and back. R1 started to stand up from her wheelchair. Facility initiated a 2 to 1 staff to R1 ratio as the facility determined R1 was not safe. R1's physician was contacted and consulted and confirmed for the R1 to be sent back to the	2 800		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 800	Continued From page 7	2 800		

hospital. R1's guardian was informed of the transfer situation.

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.

R1's progress noted dated 9/16/20, at 6:28 p.m. included, R1 was noted to have continued marked behaviors: swore at staff, attempted to put herself onto the floor, yelling and hollering louder than her usual, R1 was extremely agitated and 1:1, 2:2, 3:3 were attempted and R1 remained aggressive towards staff. Facility called 911 to send R1 to emergency department (ED) for further evaluation per physician's orders.

When interviewed on 9/24/20, at 1:00 p.m. NA-B stated there were times when R1 required one on one attention, but they only had one or two staff to cover a unit of 30 residents, so this was not possible.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated they did not have enough help to watch R1 all the time and she fell a lot.

When interviewed on 9/24/20, at 2:56 p.m. the emergency room social worker stated the facility would not take R1 back to the facility because they did not have enough help to watch her well enough.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated R1 required a significant amount of staff time to prevent her from falling and they just did not have the time to stay with her all the time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 800	Continued From page 8 NA-D stated she worked the day shift and often when arriving for her shift would find R1, "sopping wet," in her incontinent brief. When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated there was not enough staffing to supervise R1 and keep her safe as she required individual attention. When interviewed on 9/28/20, at 10:10 a.m. the DON stated due to limited staffing R1's needs could not be met at the facility, therefore R1 could not be readmitted after her last admission to the hospital. R3's admission minimum data set (MDS), dated 8/15/20, revealed R3 had moderate cognitive impairment. R3 required supervision and one staff physical assistance for eating. R1's diagnosis included a stroke. R3 had the following swallowing concerns: loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, and coughing during meals or when swallowing medications. R3's care plan, last updated 9/24/20, directed staff, "The resident needs a calm, quiet meal time with adequate eating time. The resident requires all meals in the dining room r/t [related to] close supervision-not to receive meals until supervision is provided." When interviewed on 9/24/20, at 12:56 p.m. NA-A stated she worked day shift and considered it, "understaffed." NA-A reported residents waited to be provided morning cares prior to breakfast, especially if they required two staff and assistance with mechanical lift. NA-A stated, R3 required individual assistance for cueing him to	2 800		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 800	Continued From page 9	2 800		

not eat too quickly or take too big of a bite and to get enough fluid. NA-A noted R3 often had to wait over 40 minutes to eat until they had enough staff in the dining room to help him.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated, R3 required staff to closely monitor to make sure he ate the amount he should. Often no staff were available to help, he would sit and look around the room, waiting for his plate of food.

When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated, there were several residents that required assistance in the dining room and it was difficult to figure out how to feed R3. R3 required help the entire time due to choking precautions and required assistance the entire meal time.

During observation on 9/25/20, at 12:21 p.m. R3 wheeled self into the dining room. R3 rolled his wheel chair back and forth at the table, looking around until his meal was brought to him at 12:41 p.m.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated there is never enough staff in the dining room to feed everyone. "On a good day, we are lucky to have 2 aides to assist all the residents." R8's admission MDS, dated 8/10/20, included, R8 was cognitively intact with a diagnosis of Parkinson's disease. R8 required physical assistance of 2 staff for transfers and supervision and one person physical assistance for toileting.

R8's care plan, last revised 8/24/20, directed staff, "Alteration in elimination r/t [related to] Parkinson's" and, "Assist of 1 with toileting as needed for hygiene."

When interviewed on 9/24/20, at 12:23 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 800	Continued From page 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.

When interviewed on 9/28/20, at 10:37 a.m. R8 stated there was not enough staff to help her when she needed it. R8 stated she has problems with stiffness and decreased ability to do things on her own when her Parkinson's medication was late. R8 stated staff tell her they have a half hour on each side of the time her medication is due, but it is often over that. R8 stated staff tell her they do not have enough staff to get it to her on time. R8 stated she does not get enough help to the bathroom, she often has to wait 20-40 minutes to get on or off the toilet. This causes her back to hurt and she gets even more still and unable to care for herself even more.

R8's medication administration record (MAR), dated August 2020, included an order for Carbidopa-Levodopa (a medication for treating Parkinson's disease symptoms such as muscle stiffness, tremors, spasms, and poor muscle control) five times daily; 5:55 a.m., 10:00 a.m., 4:00 p.m., 7:30 p.m. and 11:30 p.m. R8 was noted as being administered the medications at each opportunity, but the time administered was not noted.

When interviewed on 9/28/20, at 10:58 a.m. LPN-D stated R8 wanted her medications on time. LPN-D stated R8 reported concerns with getting her medications on time in the evening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 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.

R13's care plan, dated 7/3/20, incontinence and risk for skin breakdown and required staff assistance. The care plan indicated to keep the call light in reach and answer promptly.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated R13 was totally dependent on staff for cares. Sometimes R13 had to stay in bed for breakfast as they didn't have enough staff to get her up before breakfast. R13 would prefer to get up, but is agreeable when they need her to be. Often R13 would be, "saturated" by the time they were able to attend to her after breakfast.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated when coming on for the afternoon shift they would find R13 soaked in urine. NA-D was often the only staff on afternoons who was competent to use the mechanical lift needed to get R13 up, and due to this, often R13 had to stay in bed at supper time. This would upset R13, but they just didn't have enough help to always get her up.

When interviewed on 9/28/20, at 11:05 a.m. R13 stated she is incontinent of urine due to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 800	Continued From page 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, between 50 and 60 minutes on 5 occurrences and over 60 minutes on four occurrences.

R12's quarterly MDS dated 8/14/20, included, R12 had moderate cognitive impairment. R12 was on hospice services and required oxygen care. R12's diagnoses included coronary artery disease, asthma/chronic obstructive pulmonary disease or chronic lung disease and respiratory failure.

R12's medication and treatment administration report (MAR/TAR), dated August 2020, directed staff, "Connect 02 1.5 L [liters]/min [minute] at bedtime." and "Oxygen at 1.5L/min per nasal cannula while at rest and at night. This was not marked as completed on the night of 9/4/20 and 9/17/20. The MAR/TAR directed "Ensure resident has bipap on every overnight, every night shift for cpap placement. Please ensure Cpap is in place every hour overnight." This was not marked as completed on 9/4/20 and 9/17/20. and "Bipap-Nurse must put on use daily when sleeping and at night." This was not marked as completed the night of 9/4/20 and 9/17/20.

On 9/24/20, at 3:45 p.m. LPN-B stated, R12's and family had concerns about staffing. LPN-B R12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 13	2 800		

was, "slower," and "needier," than other residents.

On 9/25/20 at 10:39 a.m. a family member of R12, (FM)-A stated she monitored R12's care through video. R12 wore a bipap mask at night and oxygen nasal cannula during the day to assist with respiratory and breathing issues. FM-A would notice times R12's bipap or oxygen was not applied, or not applied properly for significant amounts of time, noting recent example between 3:20 a.m. to 3:50 a.m.; 5:00 a.m. to 7:10 a.m., and 10:10 p.m. to 1:17 a.m. on 9/24/20. FM-A reported, during these instances, she would call the facility to alert staff, without response. During the interview, R12 noted she did not feel well when she was not getting the oxygen she needed, like she was in a "daze". FM-A reported R12 was deteriorating both cognitively and physically and was more confused when not on the oxygen. FM-A stated, on 9/18/20 to 9/19/20 she noted no camera activity, indicating no movement detected, in R12's room between 11:34 p.m. and 4:09 p.m. FM-A noted R12 required frequent monitoring to ensure her bipap was on properly. FM-A reported R12 had told her she felt like a burden to staff. FM-A reported she had informed the director of nursing of her concerns and there was no resolution or improvement.

R12's call light log, dated 9/1/20 to 9/29/20, included, R12 activated the call light 66 times. Eleven of those were answered in 10 to 20 minutes. Six were answered between 20 to 30 minutes. Six were answered between 30 to 40 minutes. One was answered between 40 and 50 minutes. Six were answered in over 60 minutes

When interviewed on 9/24/20, at 12:23 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 800	Continued From page 14 LPN-A stated there were not enough staff to care for residents. LPN-A explained there were sometimes only one aide on west side of the care center. Residents were not getting the timely care they needed with timely toileting, bathing and hygiene. The workload was stressful and contributing to staff burnout and turnover. LPN-A stated, she had discussed concerns with DON and administrator and there had been no resolution. LPN-A reported she helped the nursing assistants with cares when she was able but was busy with completing treatments and medication pass for residents. LPN-A reported there was an overall concern with resident not getting the timely assistance with bathing and hygiene. When interviewed on 9/24/20, at 1:31 p.m. NA-C reported she was pulled away from her nursing assistant duties to help with electronic medical appointments and wound rounds. There was not sufficient nursing staff to provide oral care and peri-cares for residents. The nurses were too busy with their own duties to assist. Most of the time baths and showers were missed and residents were not assisted with morning and evening cares when they preferred. Staff would chart a resident refused a bath, when the resident had not been offered, or chart a resident was bathed, when they were not bathed. This had been reported to both the DON and administrator with no changes. When interviewed on 9/24/20, at 3:22 p.m. NA-D stated she worked the night shift and there were times when she would be the only nurse aid in the building. Resident call lights were on for extended periods of time- sometimes over an hour. They just could not get to them timely. At meal times residents complain of cold food.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 800	Continued From page 15 "Short staffing is a daily occurrence." This had been reported to the administrator but was told there was nothing they could do about it. When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated there was one or two aides for 30 residents. Nurses were expected to provide personal cares for 5 residents each shift in addition to their regular duties. Sometimes, they were not able to make sure resident treatments were completed. When staff come from a staffing agency, they are reluctant to return as they do not have enough time to complete all of their work. LPN-B had reported this concern to management and was told they had enough staff. When interviewed on 9/25/20, at 11:12 p.m. HSK-A stated nursing assistance seem to be, "burned out," because they do not have enough time to meet resident needs. When interviewed on 9/28/20, at 3:36 p.m. the administrator, assistant administrator, DON and RN-A were interviewed together. There was no facility assessment to determine the specific staffing needs to meet resident care planned needs. Typically, there should be 1 nursing assistant per 10 residents. DON stated there were residents who complained about call light wait times, particularly at night time. RN-A stated, "The staff have made it seem so drastic" but noticed "a lot of standing around." The administrator noted she was working on team dynamics and culture change in response to staffing concerns. The administrator reported she was committed to improving the staffing situation and chipping in within her abilities. DON reported she felt there was an adequate number of staff but felt the communication was poor. DON reported there was a situation where there was too many staff and less work got done. RN-A reported there was fewer staff because the census was down.	2 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 800	Continued From page 16 The facility staffing policy, dated 10/17, directed staff, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care ad services for all residents in accordance with resident care plans and assessment." and "Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care." SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure that adequate policy and programs are developed for sufficient staffing based on the resident population so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, and eating assistance. The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		11/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 17 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: 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: R1's quarterly Minimum Data Set (MDS) dated 8/20/20, included, severe cognitive impairment with diagnoses including TBI (traumatic brain injury) and dementia. R1 required extensive assistance with most activities of daily living (ADL's) and did not ambulate. R4 had 2 or more falls with injury since the prior assessment. R1 had a discharge MDS dated 9/16/20. R1's falls Care Area Assessment dated 5/22/20, included, "Resident triggers for falls r/t [related to] having impaired balance and daily psychotropic medication use. Resident has decreased mobility following hospitalization for a UTI [urinary tract infection] and increased behaviors. Resident was involved in a MVA [motor vehicle accident] last November and suffered multiple major injuries including but not limited to: skull fractures, TBI,	2 830	area acknowledged	

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2 830	Continued From page 18	2 830		

rib fractures, and wrist fractures." "Resident is at increased risk for falls r/t cognitive impairment, agitation, and daily use of psychotropic, anticonvulsant, antihypertensive, and benzodiazepine medications. She is incontinent of bowel and bladder. She does not have a history of falls prior to admission and has not had any falls since admission. Resident was moved to a room closer to the nurses station for safety. Plan to continue to monitor for safety, keep call light in reach, and follow therapy recommendations." The CAA indicated falls would be addressed in the care plan.

R1's admission Fall Review Evaluation dated 5/19/20, included a check list of risk factors for falls as identified in the 5/22/20 CAA. However, there was no analysis of fall risk factors or identification of interventions that may mitigate or reduce the chance of R1 falling.

R1's care plan dated 9/2/20, included, "Fall risk AEB [as evidenced by] multiple falls since admission related to lack of safety awareness secondary to TBI and Dementia with behavioral disturbances." The goal for R1 was listed as, "Resident will be safe and free from serious injury should incident occur." Staff were directed to, use one assist for transfers with a standing lift. Place bed on low position. Have fall mats on both sides of bed. Leave door open at all times unless providing cares. Use a tilt-in-space wheel chair for comfort. To be visually supervised when in wheel chair. Provide one on one care, such as taking outside and wheeling her down the hall.

R1's Action Summary dated 7/1/20 to 9/28/20, identified R1 had fallen 17 times on 7/14/20, 7/31/20, 8/1/20, 8/5/20, 8/6/20, 8/11/20, 8/12/20, 8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 19 8/21/20, 8/29/20, 9/3/20, 9/14/20 and 9/15/20. In addition, R1's progress notes dated 7/29/20 and 8/30/20 identified she had fallen, but these were not included on the Action Summary. There were no progress notes or incident reports for the falls identified on the Action Summary which were dated 8/11/20, 8/12/20 (2 falls), 8/19/20, or 9/14/20. Twelve of the falls were identified in the progress notes as being a fall from bed onto the mat next to the bed. These were on 7/31/20, 8/5/20, 8/6/20, 8/16/20 - three times, 8/21/20- 3 times, 8/29/20, 8/30/20, and 9/3/20. 2 falls were identified from a wheel chair on 8/29/20 and 9/15/20. 1 fall from recliner on 7/29/20. There was no documentation to determine the circumstances of the falls that occurred on 7/14/20, 8/11/12, 8/11/20, 8/12/20, 8/19/20 or 9/14/20. R1's Incident Review and Analysis dated 7/20/20, included, R1 was found on the floor on 7/14/20. Incident Analysis included, "Staff was walking by resident's room and saw resident lying on the floor." "Resident with lack of safety awareness which contributes to resident's fall risks due to diagnosis of unspecified TBI w/o loss of consciousness; Dementia with behavioral disturbance." The follow-up/intervention section listed: proper footwear, evaluation by PT/OT (physical therapy/occupational therapy), bed in lowest position and soft touch call light. Resident to be visually supervised when in wheelchair. Provide tilt-in-space wheelchair with the ability to recline resident when in chair to provide ore comfort. Staff providing 1:1 (one on one) care such as taking her outside and wheeling her down the hall. "Resident with behaviors and often times heard yelling. Resident requires 1:1 attention to staff and to redirect and provide reassurance. Resident is at high fall risk due to	2 830		

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2 830	Continued From page 20	2 830		

lack of safety awareness due to TBI and dementia. Resident also experiences agitation and restlessness and could be the reason of resident's self transferring to get staff's attention to tend to her." These interventions were added to the care plan.

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."

R1's progress note dated 7/31/20, included, "At 8:40 PM writer heard resident calling out from her room and found resident on the floor laying next to her bed." Abrasions were noted to both knees. There was no assessment of this fall. Interventions added were, "All staff will make sure resident's bedroom door is not closed completely and will keep bathroom light on when room is dark." Keeping the bathroom light on when the room is dark was not added to the care plan.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 21	2 830		

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 had knees on ground and torso was still in the bed. Resident was confused and wanted to leave facility."

R1's progress note dated 8/16/20, at 10:35 p.m. included, "Aid called nurse in to find resident sitting on floor with arms on the bed. Resident was wanting to leave facility."

R1's progress note dated 8/16/20, at 10:40 p.m. included, "Resident was on floor sliding off her bed. Resident had just fallen previous to this but slid out of her bed. Resident was waning [sic] to leave facility and calling out to staff "someone get me out of here."

R1's progress note dated 8/21/20, included, "Writer observed resident sitting on floor x 3 on mat next to bed this shift. No injuries noted. Bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 22	2 830		

at lowest position. Asked resident what happened and resident stated, "Trying to get out of here."

R1's progress note dated 8/29/20, included, "At 2:15 PM writer heard resident yelling from lobby. Writer found resident laying on the floor next to her W/C [wheel chair] yelling "Ow my head." Writer found 1" [inch] x 1.5" abrasion to resident's forehead. Resident was wearing appropriate footwear, foot pedals in place on W/C, and no incontinence noted. Resident unable to describe to writer what happened except that "I fell and hit my head." Cool wet towel was applied to forehead. Then found an abrasion on her knee also.

R1's progress note dated 8/30/20, included, "Writer heard repeated yelling out from resident's room and found resident on the floor next to her bed. Bed was in lowest position, call light within reach, fall mats in place both sides of bed, and resident not incontinent."

R1's progress note dated 8/30/20, noted a bruise on right index finger and a scrape on her head. There was no incident report or assessment to determine when these injuries occurred.

R1's progress note dated 8/31/20, included, the physician had been updated on bruise to right index finger.

R1's progress note dated 9/2/20, included, "Ice to sore right finger."

R1's treatment record identified staff were to monitor right index finger related to a fall. However, it did not identify which fall caused this injury.

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2 830	Continued From page 23 R1's progress note dated 9/3/20, included, "Writer heard resident yelling from her room and when writer arrived resident was sitting on the floor next to her bed yelling, "Help me get back up. Bed was in lowest position with fall mats in place and call light in reach." Even though R1 had fallen from bed 13 times, there was no comprehensive assessment to determine the reason R1 was falling from bed, any pattern in time of day or situation, or to determine why the current interventions were not working to prevent further falls. R1's progress note dated 9/10/20, included, "Monitor right index finger related to a fall." "Nail bed and part of finger appears black." R1's progress note dated 9//13/20, identified to, "Monitor right index finger related to a fall." "Patients finger continues to be black around the nail bed no redness or warmth noted to site. Nail remains intact at this time." R1's Incident Review and Analysis report dated 9/15/20, identified R1 had fallen from her wheelchair on 9/15/20. No assessment of the cause of R1's fall from the chair was completed. The form identified R1 was sent to the emergency room for evaluation due to a head wound. R1's hospital Admission History and Physical dated 9/15/20, included, "Patient was found on floor in bedroom and then seemed to throw herself on floor at nursing station. She has been agitated/verbally upset at times. Wanting to go upstairs." The results from a CT of head noted an acute nondisplaced fracture of the left	2 830		

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 24	2 830		

posterial parietal bone (skull fracture). R1's hospital discharge summary identified R1 had sustained a closed skull fracture and a fracture of her right hand 2nd finger which would be splinted before returning to the nursing home. The finger fracture was in a stage of healing, identifying it had happened in the past. The facility identified an injury to R1's right index finger in the the progress notes on 8/30/20. However, this was not assessed by a physician or x-rayed until hospitalized on 9/15/20.

When interviewed on 9/24/20, at 1:00 p.m. NA-B stated R1 had fallen from bed a lot and from her wheel chair, she was constantly trying to stand up and required one on one attention or she would fall. NA-B stated they did not have time to do one on ones with R1. NA-B did not know of any interventions that helped R1 with the agitation and trying to stand up all the time, other than to sit with her one on one, winch was not possible as other residents required care too.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated R1 had fallen frequently, she would scream and throw herself from bed. The only interventions she knew of was to have the bed in the low position and mats on the floor so when R1 did this she wouldn't be injured. NA-C remembered R1 had a large swollen egg sized area on her forehead and had broken her finger, but did not know when this occurred.

When interviewed on 9/24/20, at 3:07 p.m. R1's guardian stated they were concerned about R1 sustaining a fractured finger that went undiagnosed for so long.

When interviewed on 9/24/20, at 3:45 p.m. licensed practical nurse (LPN)-B stated R1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 25 constantly throwing herself off the bed and threatening to throw herself off the bed. There was not enough staff to do one on ones and supervision with R1. LPN-A was unable to find any assessment of R1's falls for pattern or to determine why she was falling. LPN-A stated it was R1's behaviors, but was unable to find any assessment of R1's behaviors to determine why she was, "throwing herself," out of bed. When interviewed on 9/28/20, at 10:10 a.m. the director of nursing (DON) stated they did not have a good system for when someone falls and they are trying to improve this process. The nurse should fill out an Incident Review and Analysis after each fall. The DON was only able to find 4 of these for R1's falls, which were for the falls sustained on 7/14/20, 7/31/20, 8/1/20, and 9/15/20. The DON did not know why this assessment had not been filled out for any of the other falls R1 sustained. R1 had behavioral issues and really required one on one attention, which they were unable to provided. The DON was unable to provide any assessment to determine if there was a pattern to R1's falls, and what interventions may assist R1 with her anxiety/behaviors that led to her falling so frequently. No assessment had been completed of R1's behaviors to determine interventions that may help. R4's significant change MDS dated 8/27/20, included severe cognitive impairment with a diagnosis of dementia with behavioral disturbance. R4 required extensive assist for bed mobility and dressing and total staff assistance for transfer, toileting, and personal hygiene. R4 was totally incontinent of bladder and rejected	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 26	2 830		

cares 1-3 times during the assessment period. R3 had 1 fall without injury since prior assessment.

R4's fall CAA included, "Resident triggers for falls r/t having impaired balance, history of falls, and psychotropic medication use. Resident has declined in both mobility and cognitive functions. She has recently enrolled in hospice for end of life cares. Has increased risk of falls r/t daily use of hypoglycemic, antihypertensive, diuretic, narcotic, and psychotropic medications. She is incontinent of bowel and bladder. She has had a recent fall from bed. Plan to continue to monitor for safety and keep call light within reach."

R4's care plan dated 6/26/20 indicated, "Fall risk related to [blank]. Staff were directed, "Bed in lowest position. Call light within reach; fall mat. Follow PT and OT instruction for mobility function." The most recent intervention, "Ambulate to dining room with FWW [front wheel walker] support with CGA [contact guard assist] 120 ft [feet] x1 [with 1 staff] with FWW support" was added 7/22/20. No additional updates had been made.

R4's nursing assistant Care Sheet included, "Assist of 2 w/ [with] Hoyer [mechanical lift]; Does not ambulate; fall mat; call light within reach."

R4's progress note dated 8/26/20, at 10:51 p.m. included, "At 7:35 pm nurse aide found resident lying on floor next to bed. Resident appeared agitated/anxious and continued to try and stand/yell at staff. Resident swinging arms at staff when trying to position Hoyer [mechanical lift] sling so resident assisted back up into bed with Ax2 [assist of 2 staff]. Call light was within reach; fall mat was in place next to bed; bed was in

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 27	2 830		

lowest position; room was clear of clutter and well lit." "Resident received PRN [as needed] Seroquel [antipsychotic] for increased agitation/anxiety and was asleep within the following hour. Hospice, ADON [assistant director of nursing], and emergency contact were all notified. Writer and emergency contact talked about in-facility family visits in hospices [sic] to ease resident's anxiety/agitation and emergency contact thought it would be worth a try; Emergency contact is going to try and stop for a visit tomorrow."

When interviewed on 9/28/20, at 10:00 a.m. registered nurse (RN)-A stated there was no incident report or post fall follow-up report on R4's fall. R4's care plan was incorrect about walking R4, as she is no longer able to ambulate.

When interviewed on 9/28/20, at 11:35 a.m. family member (FM)-B stated they had not been allowed to visit related to COVID and was concerned about R4's falls. FM-B stated R4 would not be able to see them out her window for a visit. No one had spoken to them about possibly visiting to decrease anxiety.

When interviewed on 9/28/20, at 12:35 p.m. LPN-D stated R4 had fallen a couple times, rolling from bed. They put a mat on the floor next to the bed and make sure R4 has her call light in reach. LPN-D stated R4 would not know how to use the call light and was unsure why that was an intervention.

When interviewed on 9/28/20, at 3:05 p.m. RN-A stated, R4 was to have increased family window visits after this fall to aide in preventing more falls. The DON stated, the interdisciplinary team should meet after each fall, update care sheets and care

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 28	2 830		

plan, and communicate the change, but the increased family visits had not been communicated to the family or added to R4's care plan. The facility was behind in updating care plans.

R3's admission MDS dated 8/15/20, included moderate cognitive impairment with diagnoses 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 risk 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 29	2 830		

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 and free from falls." Staff were directed to, Answer call light promptly, use a mechanical lift for transfers, follow therapy instructions, call light in reach, proper footwear, ensue frequently used items were in reach.

R3's progress note dated 8/10/20, at 9:31 p.m. included, "Writer was called into room when aid walked in and saw resident laying prone on the floor. Resident was next to wheelchair and was eating supper. Aid, ADON and writer helped resident up using hoyer [mechanical] lift. Resident states that he was eating and his spoon dropped and he went to go catch it and fell out of his wheelchair. Resident states he hit his nose on the chair that was next to the wheel chair."

R3's progress note dated 8/22/20, at 6:55 p.m. included, "Residents door was open and writer was at the medicine cart adjacent to the room." "Pt [patient] was attempting at self transfers and RN heard some sound that was apparently from his wheel chair and no sooner than he turned, he saw the resident fall to the floor."

R3's progress note dated 8/28/20, included, "Writer was called by aid to assist resident off the floor. Resident was on the ground on his bottom and had his hands holding onto side rail of bed. Resident was sitting crossed legged next to bed sitting up. Resident states he was getting out of his wheel chair to get into bed. Resident then slipped off the bed and onto his bottom next to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 830	Continued From page 30	2 830		

bed. Resident's vital signs were within normal limits. Resident was reminded to use his call light for all transfers."

R3's progress note dated 9/4/20, 10:32 p.m. included, R3 self transferred and was found sliding off edge of bed.

R3's progress note dated 9/11/20, included, "Resident was laying on back on the ground. Resident was holding handle gripper in hand and waiving it in the air. Residents wheelchair was right next to him with the breaks unlocked. Resident states he was chasing the cats out of his room and using the handle gripper to get them out of his way. Resident then fell out of wheelchair while doing this." "Resident was told there were no cats in this facility." There was no assessment of R3's belief there were cats in his room, even though R3 had not had hallucinations or delusions at the time of the comprehensive assessment.

When interviewed on 9/28/20, at 10:31 a.m. LPN-C stated other than what was already in the care plan, no new interventions were added after any of these falls. LPN-C was unable to provide any post fall assessment for any of these falls. The facility had not assessed each fall to determine root cause, nor place interventions to prevent the falls from happening again. R3 had increased confusion after admission, which was not assessed other than to offer psych services, which the family declined. Normally, the interdisciplinary team would assess each fall the next day and place new interventions based upon that assessment, but this had not been done for R3.

When interviewed on 9/28/20, at 11:44 a.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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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 will implement appropriate interventions to prevent serious injury from falls. 6. Care plans will be updated to reflect fall interventions."

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.

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 consistency, small bites thorough mastication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 32	2 830		

(chewing), swallow bites before taking another bite/sip, slow pacing, single sips, alternate between liquids/solids. The report indicated further analysis would be required to determine if R10 would be appropriate 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.

R10's care plan dated 4/1/20, included, risk for nutritional alteration related to coughing during meals; had diet restrictions which included NDD2 [National Dysphagia Diet, level 2- meats are to be ground or are minced no larger than 1/4 inch pieces, they are moist, with some cohesion] diet and could have requested puree. Staff were directed to monitor, document, and report to the physician as needed for signs and symptoms of swallowing problems.

R10's undated nursing assistant Care Guide included mechanical soft diet with pureed meat.

R10's Nutrition Evaluation dated 4/16/20, identified a mechanical soft diet with pureed meat. Speech therapy recommended to, "have all meats ground, unless resident request pureed for preference."

R10's Oral/Dental Evaluation dated 7/14/20, indicated R10 had full upper and lower dentures.

During observation on 9/25/20, at 12:42 p.m. R10 was observed to be coughing while eating. At 12:47 p.m. it was noted R10 was eating a regular hamburger patty on a bun. R10 stated it was hard to eat because she did not have her dentures in. She had requested the regular patty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 33	2 830		

as the staff had grilled out the burgers and she desired one. R10 continued to cough while eating, no one checked to see if she was alright, nor did anyone bring her dentures.

R10's lunch tray ticket included, "Mechanical soft texture and to provide ground grilled hamburger, potato salad, no raw veggies, beans, shredded lettuce."

When interviewed on 9/25/20, at 1:06 p.m. dietary aide (DA)-A stated residents who require a mechanical soft diet should have been provided with ground meat. R10 coughing is something she normally does while eating.

When interviewed on 9/25/20, at 1:12 p.m. cook (CK)-A stated, a mechanical soft diet should have ground meat, no bread or hard vegetables. The cook is the person responsible to ensure the correct diet is served.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated R10 does cough at meals, she was unaware R10 did not have dentures in. NA-F stated if someone is coughing like that, they should go get a nurse to assess if no nurse was in the dining room.

When interviewed on 9/25/20, at 1:34 p.m. R10 stated she normally gets a ground burger, but today got a regular whole burger as they were grilling them. R10 stated she normally wore her dentures, but forgot them today. Staff sometimes have to remind her to put them in or help her with them. At 1:39 p.m. R10 was coughing and NA-H asked her if she was ok.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated resident's diets could be upgraded if they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 34	2 830		

wished for an upgrade, but would have to sign a risk versus benefits statement. R10 did not have a risk versus benefits statement signed nor was she given the risks of choking when provided with a regular hamburger today.

When interviewed on 9/25/20, at 3:08 p.m. Cook-A stated they have a file of each resident who had signed a risk versus benefits statement for a diet upgrade, then if they ask for an upgrade they can provide it. R10 did not have one of these. R10 should have been provided the ground meat diet as ordered and not a regular hamburger.

R10's Diet Requisition Form provided by Cook-A and dated 3/31/20, had been completed by speech therapy and indicated R10 was to have a Mechanical Soft/Ground Meat NDD2 diet consistency and patient could downgrade to pureed food if desired.

When interviewed on 9/28/20, at 10:21 p.m. the registered dietician (RD) stated if a resident were coughing during a meal it should be reported to the DON, food service director and speech therapy. This had not been done for R10. The facility should not provide an upgraded texture diet without risks being explained to the resident and a form signed.

When interviewed on 9/28/20, at 2:37 p.m. the DON and RN-A stated it is important to provide the correct diet texture for residents with swallowing problems. A nurse should be notified if a resident is coughing.

R5's quarterly MDS dated 9/4/20, indicated no cognitive impairment with diagnoses including,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 35	2 830		

stroke, epilepsy. The MDS noted R5 had coughing and choking during meals or when swallowing medications during the assessment period. The MDS further indicated supervision, oversite, set up when eating and mechanically altered textures.

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.

R5's Care Assessment Area Worksheet (CAA) dated 1/20/20, indicated R5 required a mechanically altered diet. There was no analysis completed, but was noted to proceed to care planning.

R5's care plan dated 3/20/20, indicated R5 was at risk for nutritional alteration related to chronic pain front thorax and diet restriction for NDD3 diet. Staff were directed to monitor, document and report to physician for signs or symptoms of dysphagia when eating.

R5's Progress note dated, 1/25/19, indicated her diet was changed to NDD3 by Speech therapy.

R5's Nutritional Evaluation dated 9/4/20, identified a diet order for NDD3, Dysphagia Advanced diet level 3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 36 R5's Care guide for staff indicated a regular diet and independent in dining room which is different from MDS 9/4/20, CAA 1/20/20, Medical Record, physician order and care plan. R5's lunch tray ticket included a diet order for Dysphagia Advanced diet (NDD3). The tray ticket further directed to provide chopped, grilled hamburger on bun, potato salad, no raw vegetables, backed beans, no bacon, shredded lettuce, soft ice cream and milk. During an observation on 9/25/20, at 12:50 p.m. R5 sat alone at a table and was noted to cough while she ate her meal. R5's plate contained a whole hamburger with a wedge of lettuce that covered the burger on a bun and potato chips. There were various staff throughout the dining area including nursing and dietary, but no one stopped to see why R5 was coughing. At 12:52 p.m. R5 was observed to be shaking and asked for someone get a nurse because she was having a seizure. Staff came and brought R5 out of the dining room. When interviewed on 9/25/20, at 1:06 p.m. DA-A stated R5 should have received ground meat, beans, potato salad, soft cooked vegetables. R5 should not have had a bun, the burger should have been ground and should not have received potato chips or whole leaf lettuce. When interviewed on 9/25/20, at 1:10 p.m. R5 stated she has occasional seizure that are like, "spells," and has no diet restrictions. When interviewed on 9/25/20, at 1:12 p.m. Cook-A stated the facility provided NDD3, NDD2 and pureed textures. A mechanical diet should have ground meat, no bread or hard vegetables.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 37 For the noon meal provided on 9/25/20, a mechanical texture should have included, no bun, ground hamburger, potato salad and beans. It was the cook's responsibility to make sure a resident is getting the appropriate texture. When interviewed on 9/25/20, at 1:21 p.m. NA-F stated staff should check on residents who are coughing and should get a nurse. R5 should have received the correct diet and did not know who gave her the wrong diet. When interviewed on 9/25/20, at 1:40 p.m. Dietary Aide-A reported both dietary and nursing aides deliver meal trays. When interviewed on 9/25/20, at 3:06 p.m. RN-B stated a resident is ok to be provided an upgraded texture if a risk and benefit form had been signed. The resident should be given the order from the physician if there is no signed risk and benefit form. R5 did not have a signed form. On 9/25/20 at 3:08 p.m. Cook-A- stated R5 should have received the ordered diet, but did not, the Cook is responsible for providing the correct diet. The facility Refusal of Care/Interventions, Risk and Benefits policy dated 9/11, identified a resident would be informed of the risk and benefits of necessary care and given the opportunity regarding their decision in the plan of care. The resident would be approached 2-3 times and if resident continued to refuse, documentation should be made on the Refusal of Care Interventions Risk and Benefits and reviewed quarterly. The National Dysphagia Diet indicated NDD2 as	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 38 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 soft, well-cooked vegetables. Vegetables should be less than 1/2 inch and should be easily mashed with a fork. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours,	2 905		11/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 39 including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. 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. Findings include: R4's significant change Minimum Data Set (MDS) dated 8/27/20, included severe cognitive impairment with a diagnosis of dementia. R4 required extensive assist for bed mobility and total staff assistance for transfer. R4 was at risk for pressure ulcer development, but did not have a current pressure ulcer. R4's pressure ulcer Care Area Assessment (CAA) dated 8/28/20 included, "Resident triggers for pressure r/t [related to] need for assistance with bed mobility and bowel and bladder incontinence. Resident is at risk for skin break down r/t cognitive impairment, dx [diagnosis] of HTN [hypertension] and Type 2 DM [diabetes] and daily use of ASA [aspirin] and Coumadin [blood thinner]. She is incontinent of bowel and bladder. Resident noted to have scabbed area over skin tear on LLE [lower left extremity]. Skin otherwise intact. Preventative skin measures in place with toileting and repositioning q [every] 2 hours, pressure redistribution cushion to wheelchair and mattress to bed, routine skin cares q [every] AM [morning] and HS [night], and	2 905	Area acknowledged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 905	Continued From page 40 weekly skin inspections." R4's care plan dated 6/26/20 included, "Potential alteration in skin integrity." Staff were directed to, "Monitor skin integrity daily. Weekly skin inspection by nurse. Treatment to open areas per order. Pressure redistribution mattress to bed. Pressure redistribution cushion to wheelchair, chair." Care plan interventions updated 9/1/20. R4's care plan further indicated, "Alteration in mobility related to end of life" with interventions: "Dependent with bed mobility: A1-2 [assist of 1-2 staff]. Maxi lift (Hoyer) [mechanical lift] with transfers. Turn and reposition Q2H [every 2 hours]." Additionally R4's care plan specified, "Alteration in comfort," with an intervention dated 9/8/20: "Position q2hrs [every 2 hours] and PRN [as needed] with pillows for comfort." R4's nursing assistant Care Sheet included, "Assist of 2 w/ [with] Hoyer [mechanical lift]; does not ambulate." The care sheet did not direct staff on how often to assist R4 with turning and repositioning. A Hospice Facility Visit progress note dated 9/3/20 included, "Does verbalize some discomfort to bottom." During continuous observation on 9/25/20, starting at 10:25 a.m. R4 was attempting to adjust herself in the wheelchair, but was not able to effectively adjust herself. At 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. The 2 staff members offered to recline R4's wheelchair. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to reposition occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 905	Continued From page 41	2 905		

sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining room. At 1:55 p.m. nursing assistant (NA)-F and 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 terrible 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.

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 staff 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."

SUGGESTED METHOD OF CORRECTION:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 905	Continued From page 42 The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary repositioning treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide incontinence care timely, and failed to reassess continence status after a significant change for 1 of 3 residents (R3) reviewed for incontinence. Findings include: R4's admission Minimum Data Set (MDS) dated 6/29/20, included, moderate cognitive impairment with diagnoses including diabetes, dementia and arthritis. R4 required extensive assistance with	2 920	area acknowledged	11/2/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 920	Continued From page 43	2 920		

toileting and limited assistance with personal hygiene. R4 was not on a toileting program and was occasionally incontinent of urine (less than 7 times during the assessment period).

R4's incontinence Care Area Assessment (CAA) dated 7/1/20 indicated, "Resident triggers for urinary incontinence r/t [related to] need for assistance with toilet use and bladder incontinence." "She is in PT [physical therapy] and OT [occupational therapy] at this time with the goal of returning to the community. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's significant change MDS dated 8/27/20, included severe cognitive impairment, was totally dependent upon staff for toileting and personal hygiene and was always incontinent of urine.

R4's incontinence CAA dated 8/28/20 included, "Resident triggers for urinary incontinence r/t toilet use and bladder incontinence. Resident has declined in both mobility and cognitive function. She has recently enrolled in hospice for end of life cares. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's only Bowel and Bladder assessment in the medical record was dated 6/24/20, and indicated R4 was continent of bowel and bladder.

R4's care plan dated 6/26/20, included, "Alteration with elimination." Staff were directed to, "Assist of 1 with toileting." The care plan had

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 920	Continued From page 44	2 920		

not been updated since 6/26/20, even though the 8/27/20, MDS noted a decline in urinary incontinence to totally incontinent and an increase in assistance needs for toileting and personal hygiene.

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.

During continuous observation on 9/25/20, starting at 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to provide incontinence cares occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. LPN-D then brought R4 to the dining room. Incontinence cares were not provided. At 1:58 p.m. NA-F and NA-B assisted R4 into bed and changed R4's visibly wet brief.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 920	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 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 (21) days.	2 920		

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21810	Continued From page 46	21810		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 1 resident (R7) reviewed for dignity concerns. Findings include: R7's admission Minimum Date Set (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. 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. R7's care plan dated 7/29/20, included, R7 required assistance for, "Bathing with max to dependent assist, dressing with max assist, personal hygiene set-up with minimal assist,	21810	area acknowledged	11/2/20

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21810	Continued From page 47 occasionally incontinent, and requires assistance with toilet use." 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 night shift is customarily staffed with two NA's and 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 state there is insufficient staff to meet the individual needs of each resident. The morale among staff and residents is low because of this. R7 being incontinent due to not being able to get to her timely is a dignity issue.	21810		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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21810	Continued From page 48 R7's call light response time logs dated from 9/22/20, at 3:51 a.m. to 9/28/20, 9:25 a.m. showed the call light was engaged 51 times over the seven day period. Of the 51 call light alerts initiated, 11 (or 21.5%) of these alerts took over 15 minutes to receive a response. Seven (or 14%) of these alerts took longer than 20 minutes to receive a response. During a phone call interview on 9/28/20, at 3:30 p.m. the administrator stated they do not have a staffing or facility assessment in place to assist in determining staffing needs at this time. The administrator stated current staffing rations include one staff member for every ten residents. "More comradery and better communication," was needed among the staff. These measures would improve care. The administrator stated that they are working on this initiative. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and revise procedures to ensure residents recieve the care they need in a timely fashion. It could also address other residents that may be at risk for the same concern. The facility could educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/24/20, 9/25/20 and 9/28/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED with a licensing order issued: H5090056C: MN Rule 4658.0520 Subp. 1 H5090057C MN Rule 4658.0510 Subp. 1 and MN Rule 4658.0525 Subp. 6 B H5090059C MN Rule 4658.0510 Subp. 1; MN Rule 4658.0525 Subp. 6 B.; and MN Rule 4658.0525 Subp.4 The following complaints were found to be unsubstantiated: H5090055C and H5090058C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide for the individualized care planned needs for 8 of 8 residents (R5, R7, R4, R1, R3, R8, R13 and R12), 12 of 15 staff (LPN-B, LPN-A, LPN-D, NA-D, NA-C, NA-J, NA-B, NA-F,	2 800		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 800	Continued From page 2 NA-A, RN-A, HSK-A and NA-C) and 1 of 3 family members (FM)-A, reviewed for sufficient staffing. This had the potential to affect all 42 current residents. Findings include: R5's quarterly Minimum Data Set dated 9/4/20, included cognitively intact with diagnoses of stroke with paralysis or weakness on one side of the body and a seizure disorder. R5 required physical assistance from staff for toileting and bathing. R5 Care Assessment Worksheet (CAA) dated 1/20/20, included, R5 extensive assistance with activities of daily living (ADL) including bathing and toileting. R5's care plan updated 8/12/20, included, R5 needed assistance with toilet use and shower/bath with one assist twice a week on Sunday and Wednesday evenings with skin checks. When interviewed on 9/24/20, at 12:23 p.m. licensed practical nurse (LPN)-A stated, R5 was not getting the timely care she needed with toileting, bathing and hygiene as there was not enough staff. R5 did complain about this. 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."	2 800		

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2 800	Continued From page 3 This was upsetting to R5. When interviewed on 9/24/20, at 3:22 p.m. a nursing assistant (NA)-D stated R5 required assistance with bathing and toileting, but often she had to wait for assistance as they do not have enough staff to get to everyone timely. Sometimes they have to skip R5's bath as they do not have enough 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. R5's Grievance/Concern Report included, R5 did not receive a bath or shower on 7/22/20. NA-I stated, "R5's shower did not get done on Sunday evening due to time." NA-J stated, "R5's shower did not get done due to running out of time. Her bath requires two aids which [NA-I] and I were the only two on the floor until 6 p.m. After 6 we still had a lot to do and ended up not having enough time to get in the bath R5 wanted. There was also another shower that was supposed to get done that we never got done." Shower/bath records dated July to September 2020: R5 received a shower on 7/19 but not again until 8/17/20, and then not again until 8/24//20. R5 received a bath on 9/13/20, but not again until 9/21/20. Review of R5's call light log from 9/1/20 (6:53 p.m.) to 9/29/20 (2:24 p.m.), indicated, R5 used the call light 166 times. Of the 166 instances, the wait time was over 20 minutes on 69 occasions or 41.5% of the time.	2 800		

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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. 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. R7's care plan dated 7/29/20, included, R7 required assistance for, "Bathing with max to dependent assist, dressing with max assist, personal hygiene set-up with minimal assist, occasionally incontinent, and requires assistance with toilet use." When interviewed on 9/24/20, at 1:31 p.m. a 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.	2 800		

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2 800	Continued From page 5 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 and 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 the individual needs of each resident. The morale among staff and residents is low because of this. R7's call light response time logs dated from 9/22/20, at 3:51 a.m. to 9/28/20, 9:25 a.m. showed the call light was engaged 51 times over the seven day period. Of the 51 call light alerts initiated, 11 (or 21.5%) of these alerts took over 15 minutes to receive a response. Seven (or 14%) of these alerts took longer than 20 minutes to receive a response. R1's quarterly Minimum Data Set (MDS) dated 8/20/20, included, severe cognitive impairment with diagnoses including TBI (traumatic brain injury) and dementia. R1 required extensive assistance with most activities of daily living (ADL's) and did not ambulate. R1 had 2 or more falls with injury since the prior assessment. R1 had a discharge MDS dated 9/16/20.	2 800		

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2 800	Continued From page 6 R1's care plan dated 9/2/20, included, "Fall risk AEB [as evidenced by] multiple falls since admission related to lack of safety awareness secondary to TBI and Dementia with behavioral disturbances." The goal for R1 was listed as, "Resident will be safe and free from serious injury should incident occur." Staff were directed to, "Provide one on one care, such as taking outside and wheeling her down the hall." The facility provided a running list of R1's falls from 7/21/20 thorough 9/24/20, which indicated R1 had fallen in the facility 17 times in that time frame. 7/14/20, 7/31/20, 8/1/20, 8/5/20, 8/6/20, 8/11/20, 8/12/20, 8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20, 8/21/20, 8/29/20, 9/3/20, 9/14/20 and 9/15/20. Hospital discharge summary dated 9/16/20, indicated R1 was transferred to the hospital on 9/15/20 after sustaining a fall related to increased agitation. Summary details R1 incurred a fractured skull and finger. R1's progress notes from 9/16/20 to 9/21/20, revealed: -9/16/20, at 4:36 p.m. R1 returned to the facility from the hospital. R1's progress note dated 9/16/20, at 5:35 p.m. included R1 had attempted to crawl out of bed several times after returning from the hospital. Facility transferred R1 to her wheelchair, R1 then started to yell out and reported of pain in neck and back. R1 reported to facility of pain in her neck and back. R1 started to stand up from her wheelchair. Facility initiated a 2 to 1 staff to R1 ratio as the facility determined R1 was not safe. R1's physician was contacted and consulted and confirmed for the R1 to be sent back to the	2 800		

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2 800	Continued From page 7 hospital. R1's guardian was informed of the transfer situation. 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. R1's progress noted dated 9/16/20, at 6:28 p.m. included, R1 was noted to have continued marked behaviors: swore at staff, attempted to put herself onto the floor, yelling and hollering louder than her usual, R1 was extremely agitated and 1:1, 2:2, 3:3 were attempted and R1 remained aggressive towards staff. Facility called 911 to send R1 to emergency department (ED) for further evaluation per physician's orders. When interviewed on 9/24/20, at 1:00 p.m. NA-B stated there were times when R1 required one on one attention, but they only had one or two staff to cover a unit of 30 residents, so this was not possible. When interviewed on 9/24/20, at 1:31 p.m. NA-C stated they did not have enough help to watch R1 all the time and she fell a lot. When interviewed on 9/24/20, at 2:56 p.m. the emergency room social worker stated the facility would not take R1 back to the facility because they did not have enough help to watch her well enough. When interviewed on 9/24/20, at 3:22 p.m. NA-D stated R1 required a significant amount of staff time to prevent her from falling and they just did not have the time to stay with her all the time.	2 800		

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2 800	Continued From page 8 NA-D stated she worked the day shift and often when arriving for her shift would find R1, "sopping wet," in her incontinent brief. When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated there was not enough staffing to supervise R1 and keep her safe as she required individual attention. When interviewed on 9/28/20, at 10:10 a.m. the DON stated due to limited staffing R1's needs could not be met at the facility, therefore R1 could not be readmitted after her last admission to the hospital. R3's admission minimum data set (MDS), dated 8/15/20, revealed R3 had moderate cognitive impairment. R3 required supervision and one staff physical assistance for eating. R1's diagnosis included a stroke. R3 had the following swallowing concerns: loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, and coughing during meals or when swallowing medications. R3's care plan, last updated 9/24/20, directed staff, "The resident needs a calm, quiet meal time with adequate eating time. The resident requires all meals in the dining room r/t [related to] close supervision-not to receive meals until supervision is provided." When interviewed on 9/24/20, at 12:56 p.m. NA-A stated she worked day shift and considered it, "understaffed." NA-A reported residents waited to be provided morning cares prior to breakfast, especially if they required two staff and assistance with mechanical lift. NA-A stated, R3 required individual assistance for cueing him to	2 800		

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2 800	Continued From page 9	2 800		

not eat too quickly or take too big of a bite and to get enough fluid. NA-A noted R3 often had to wait over 40 minutes to eat until they had enough staff in the dining room to help him.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated, R3 required staff to closely monitor to make sure he ate the amount he should. Often no staff were available to help, he would sit and look around the room, waiting for his plate of food.

When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated, there were several residents that required assistance in the dining room and it was difficult to figure out how to feed R3. R3 required help the entire time due to choking precautions and required assistance the entire meal time.

During observation on 9/25/20, at 12:21 p.m. R3 wheeled self into the dining room. R3 rolled his wheel chair back and forth at the table, looking around until his meal was brought to him at 12:41 p.m.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated there is never enough staff in the dining room to feed everyone. "On a good day, we are lucky to have 2 aides to assist all the residents." R8's admission MDS, dated 8/10/20, included, R8 was cognitively intact with a diagnosis of Parkinson's disease. R8 required physical assistance of 2 staff for transfers and supervision and one person physical assistance for toileting.

R8's care plan, last revised 8/24/20, directed staff, "Alteration in elimination r/t [related to] Parkinson's" and, "Assist of 1 with toileting as needed for hygiene."

When interviewed on 9/24/20, at 12:23 p.m.

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2 800	Continued From page 10 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. When interviewed on 9/28/20, at 10:37 a.m. R8 stated there was not enough staff to help her when she needed it. R8 stated she has problems with stiffness and decreased ability to do things on her own when her Parkinson's medication was late. R8 stated staff tell her they have a half hour on each side of the time her medication is due, but it is often over that. R8 stated staff tell her they do not have enough staff to get it to her on time. R8 stated she does not get enough help to the bathroom, she often has to wait 20-40 minutes to get on or off the toilet. This causes her back to hurt and she gets even more still and unable to care for herself even more. R8's medication administration record (MAR), dated August 2020, included an order for Carbidopa-Levodopa (a medication for treating Parkinson's disease symptoms such as muscle stiffness, tremors, spasms, and poor muscle control) five times daily; 5:55 a.m., 10:00 a.m., 4:00 p.m., 7:30 p.m. and 11:30 p.m. R8 was noted as being administered the medications at each opportunity, but the time administered was not noted. When interviewed on 9/28/20, at 10:58 a.m. LPN-D stated R8 wanted her medications on time. LPN-D stated R8 reported concerns with getting her medications on time in the evening.	2 800		

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2 800	Continued From page 11 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. R13's care plan, dated 7/3/20, incontinence and risk for skin breakdown and required staff assistance. The care plan indicated to keep the call light in reach and answer promptly. When interviewed on 9/24/20, at 1:31 p.m. NA-C stated R13 was totally dependent on staff for cares. Sometimes R13 had to stay in bed for breakfast as they didn't have enough staff to get her up before breakfast. R13 would prefer to get up, but is agreeable when they need her to be. Often R13 would be, "saturated" by the time they were able to attend to her after breakfast. When interviewed on 9/24/20, at 3:22 p.m. NA-D stated when coming on for the afternoon shift they would find R13 soaked in urine. NA-D was often the only staff on afternoons who was competent to use the mechanical lift needed to get R13 up, and due to this, often R13 had to stay in bed at supper time. This would upset R13, but they just didn't have enough help to always get her up. When interviewed on 9/28/20, at 11:05 a.m. R13 stated she is incontinent of urine due to her	2 800		

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2 800	Continued From page 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, between 50 and 60 minutes on 5 occurrences and over 60 minutes on four occurrences.

R12's quarterly MDS dated 8/14/20, included, R12 had moderate cognitive impairment. R12 was on hospice services and required oxygen care. R12's diagnoses included coronary artery disease, asthma/chronic obstructive pulmonary disease or chronic lung disease and respiratory failure.

R12's medication and treatment administration report (MAR/TAR), dated August 2020, directed staff, "Connect 02 1.5 L [liters]/min [minute] at bedtime." and "Oxygen at 1.5L/min per nasal cannula while at rest and at night. This was not marked as completed on the night of 9/4/20 and 9/17/20. The MAR/TAR directed "Ensure resident has bipap on every overnight, every night shift for cpap placement. Please ensure Cpap is in place every hour overnight." This was not marked as completed on 9/4/20 and 9/17/20. and "Bipap-Nurse must put on use daily when sleeping and at night." This was not marked as completed the night of 9/4/20 and 9/17/20.

On 9/24/20, at 3:45 p.m. LPN-B stated, R12's and family had concerns about staffing. LPN-B R12

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2 800	Continued From page 13 was, "slower," and "needier," than other residents. On 9/25/20 at 10:39 a.m. a family member of R12, (FM)-A stated she monitored R12's care through video. R12 wore a bipap mask at night and oxygen nasal cannula during the day to assist with respiratory and breathing issues. FM-A would notice times R12's bipap or oxygen was not applied, or not applied properly for significant amounts of time, noting recent example between 3:20 a.m. to 3:50 a.m.; 5:00 a.m. to 7:10 a.m., and 10:10 p.m. to 1:17 a.m. on 9/24/20. FM-A reported, during these instances, she would call the facility to alert staff, without response. During the interview, R12 noted she did not feel well when she was not getting the oxygen she needed, like she was in a "daze". FM-A reported R12 was deteriorating both cognitively and physically and was more confused when not on the oxygen. FM-A stated, on 9/18/20 to 9/19/20 she noted no camera activity, indicating no movement detected, in R12's room between 11:34 p.m. and 4:09 p.m. FM-A noted R12 required frequent monitoring to ensure her bipap was on properly. FM-A reported R12 had told her she felt like a burden to staff. FM-A reported she had informed the director of nursing of her concerns and there was no resolution or improvement. R12's call light log, dated 9/1/20 to 9/29/20, included, R12 activated the call light 66 times. Eleven of those were answered in 10 to 20 minutes. Six were answered between 20 to 30 minutes. Six were answered between 30 to 40 minutes. One was answered between 40 and 50 minutes. Six were answered in over 60 minutes When interviewed on 9/24/20, at 12:23 p.m.	2 800		

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2 800	Continued From page 14 LPN-A stated there were not enough staff to care for residents. LPN-A explained there were sometimes only one aide on west side of the care center. Residents were not getting the timely care they needed with timely toileting, bathing and hygiene. The workload was stressful and contributing to staff burnout and turnover. LPN-A stated, she had discussed concerns with DON and administrator and there had been no resolution. LPN-A reported she helped the nursing assistants with cares when she was able but was busy with completing treatments and medication pass for residents. LPN-A reported there was an overall concern with resident not getting the timely assistance with bathing and hygiene. When interviewed on 9/24/20, at 1:31 p.m. NA-C reported she was pulled away from her nursing assistant duties to help with electronic medical appointments and wound rounds. There was not sufficient nursing staff to provide oral care and peri-cares for residents. The nurses were too busy with their own duties to assist. Most of the time baths and showers were missed and residents were not assisted with morning and evening cares when they preferred. Staff would chart a resident refused a bath, when the resident had not been offered, or chart a resident was bathed, when they were not bathed. This had been reported to both the DON and administrator with no changes. When interviewed on 9/24/20, at 3:22 p.m. NA-D stated she worked the night shift and there were times when she would be the only nurse aid in the building. Resident call lights were on for extended periods of time- sometimes over an hour. They just could not get to them timely. At meal times residents complain of cold food.	2 800		

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2 800	Continued From page 15 "Short staffing is a daily occurrence." This had been reported to the administrator but was told there was nothing they could do about it. When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated there was one or two aides for 30 residents. Nurses were expected to provide personal cares for 5 residents each shift in addition to their regular duties. Sometimes, they were not able to make sure resident treatments were completed. When staff come from a staffing agency, they are reluctant to return as they do not have enough time to complete all of their work. LPN-B had reported this concern to management and was told they had enough staff. When interviewed on 9/25/20, at 11:12 p.m. HSK-A stated nursing assistance seem to be, "burned out," because they do not have enough time to meet resident needs. When interviewed on 9/28/20, at 3:36 p.m. the administrator, assistant administrator, DON and RN-A were interviewed together. There was no facility assessment to determine the specific staffing needs to meet resident care planned needs. Typically, there should be 1 nursing assistant per 10 residents. DON stated there were residents who complained about call light wait times, particularly at night time. RN-A stated, "The staff have made it seem so drastic" but noticed "a lot of standing around." The administrator noted she was working on team dynamics and culture change in response to staffing concerns. The administrator reported she was committed to improving the staffing situation and chipping in within her abilities. DON reported she felt there was an adequate number of staff but felt the communication was poor. DON reported there was a situation where there was too many staff and less work got done. RN-A reported there was fewer staff because the census was down.	2 800		

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2 800	Continued From page 16 The facility staffing policy, dated 10/17, directed staff, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care ad services for all residents in accordance with resident care plans and assessment." and "Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care." SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure that adequate policy and programs are developed for sufficient staffing based on the resident population so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, and eating assistance. The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		

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2 830	Continued From page 17 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: 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: R1's quarterly Minimum Data Set (MDS) dated 8/20/20, included, severe cognitive impairment with diagnoses including TBI (traumatic brain injury) and dementia. R1 required extensive assistance with most activities of daily living (ADL's) and did not ambulate. R4 had 2 or more falls with injury since the prior assessment. R1 had a discharge MDS dated 9/16/20. R1's falls Care Area Assessment dated 5/22/20, included, "Resident triggers for falls r/t [related to] having impaired balance and daily psychotropic medication use. Resident has decreased mobility following hospitalization for a UTI [urinary tract infection] and increased behaviors. Resident was involved in a MVA [motor vehicle accident] last November and suffered multiple major injuries including but not limited to: skull fractures, TBI,	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 18	2 830		

rib fractures, and wrist fractures." "Resident is at increased risk for falls r/t cognitive impairment, agitation, and daily use of psychotropic, anticonvulsant, antihypertensive, and benzodiazepine medications. She is incontinent of bowel and bladder. She does not have a history of falls prior to admission and has not had any falls since admission. Resident was moved to a room closer to the nurses station for safety. Plan to continue to monitor for safety, keep call light in reach, and follow therapy recommendations." The CAA indicated falls would be addressed in the care plan.

R1's admission Fall Review Evaluation dated 5/19/20, included a check list of risk factors for falls as identified in the 5/22/20 CAA. However, there was no analysis of fall risk factors or identification of interventions that may mitigate or reduce the chance of R1 falling.

R1's care plan dated 9/2/20, included, "Fall risk AEB [as evidenced by] multiple falls since admission related to lack of safety awareness secondary to TBI and Dementia with behavioral disturbances." The goal for R1 was listed as, "Resident will be safe and free from serious injury should incident occur." Staff were directed to, use one assist for transfers with a standing lift. Place bed on low position. Have fall mats on both sides of bed. Leave door open at all times unless providing cares. Use a tilt-in-space wheel chair for comfort. To be visually supervised when in wheel chair. Provide one on one care, such as taking outside and wheeling her down the hall.

R1's Action Summary dated 7/1/20 to 9/28/20, identified R1 had fallen 17 times on 7/14/20, 7/31/20, 8/1/20, 8/5/20, 8/6/20, 8/11/20, 8/12/20, 8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 19 8/21/20, 8/29/20, 9/3/20, 9/14/20 and 9/15/20. In addition, R1's progress notes dated 7/29/20 and 8/30/20 identified she had fallen, but these were not included on the Action Summary. There were no progress notes or incident reports for the falls identified on the Action Summary which were dated 8/11/20, 8/12/20 (2 falls), 8/19/20, or 9/14/20. Twelve of the falls were identified in the progress notes as being a fall from bed onto the mat next to the bed. These were on 7/31/20, 8/5/20, 8/6/20, 8/16/20 - three times, 8/21/20- 3 times, 8/29/20, 8/30/20, and 9/3/20. 2 falls were identified from a wheel chair on 8/29/20 and 9/15/20. 1 fall from recliner on 7/29/20. There was no documentation to determine the circumstances of the falls that occurred on 7/14/20, 8/11/12, 8/11/20, 8/12/20, 8/19/20 or 9/14/20. R1's Incident Review and Analysis dated 7/20/20, included, R1 was found on the floor on 7/14/20. Incident Analysis included, "Staff was walking by resident's room and saw resident lying on the floor." "Resident with lack of safety awareness which contributes to resident's fall risks due to diagnosis of unspecified TBI w/o loss of consciousness; Dementia with behavioral disturbance." The follow-up/intervention section listed: proper footwear, evaluation by PT/OT (physical therapy/occupational therapy), bed in lowest position and soft touch call light. Resident to be visually supervised when in wheelchair. Provide tilt-in-space wheelchair with the ability to recline resident when in chair to provide ore comfort. Staff providing 1:1 (one on one) care such as taking her outside and wheeling her down the hall. "Resident with behaviors and often times heard yelling. Resident requires 1:1 attention to staff and to redirect and provide reassurance. Resident is at high fall risk due to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 20	2 830		

lack of safety awareness due to TBI and dementia. Resident also experiences agitation and restlessness and could be the reason of resident's self transferring to get staff's attention to tend to her." These interventions were added to the care plan.

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."

R1's progress note dated 7/31/20, included, "At 8:40 PM writer heard resident calling out from her room and found resident on the floor laying next to her bed." Abrasions were noted to both knees. There was no assessment of this fall. Interventions added were, "All staff will make sure resident's bedroom door is not closed completely and will keep bathroom light on when room is dark." Keeping the bathroom light on when the room is dark was not added to the care plan.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 21	2 830		

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 had knees on ground and torso was still in the bed. Resident was confused and wanted to leave facility."

R1's progress note dated 8/16/20, at 10:35 p.m. included, "Aid called nurse in to find resident sitting on floor with arms on the bed. Resident was wanting to leave facility."

R1's progress note dated 8/16/20, at 10:40 p.m. included, "Resident was on floor sliding off her bed. Resident had just fallen previous to this but slid out of her bed. Resident was waning [sic] to leave facility and calling out to staff "someone get me out of here."

R1's progress note dated 8/21/20, included, "Writer observed resident sitting on floor x 3 on mat next to bed this shift. No injuries noted. Bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 22 at lowest position. Asked resident what happened and resident stated, "Trying to get out of here." R1's progress note dated 8/29/20, included, "At 2:15 PM writer heard resident yelling from lobby. Writer found resident laying on the floor next to her W/C [wheel chair] yelling "Ow my head." Writer found 1" [inch] x 1.5" abrasion to resident's forehead. Resident was wearing appropriate footwear, foot pedals in place on W/C, and no incontinence noted. Resident unable to describe to writer what happened except that "I fell and hit my head." Cool wet towel was applied to forehead. Then found an abrasion on her knee also. R1's progress note dated 8/30/20, included, "Writer heard repeated yelling out from resident's room and found resident on the floor next to her bed. Bed was in lowest position, call light within reach, fall mats in place both sides of bed, and resident not incontinent." R1's progress note dated 8/30/20, noted a bruise on right index finger and a scrape on her head. There was no incident report or assessment to determine when these injuries occurred. R1's progress note dated 8/31/20, included, the physician had been updated on bruise to right index finger. R1's progress note dated 9/2/20, included, "Ice to sore right finger." R1's treatment record identified staff were to monitor right index finger related to a fall. However, it did not identify which fall caused this injury.	2 830		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 23 R1's progress note dated 9/3/20, included, "Writer heard resident yelling from her room and when writer arrived resident was sitting on the floor next to her bed yelling, "Help me get back up. Bed was in lowest position with fall mats in place and call light in reach." Even though R1 had fallen from bed 13 times, there was no comprehensive assessment to determine the reason R1 was falling from bed, any pattern in time of day or situation, or to determine why the current interventions were not working to prevent further falls. R1's progress note dated 9/10/20, included, "Monitor right index finger related to a fall." "Nail bed and part of finger appears black." R1's progress note dated 9//13/20, identified to, "Monitor right index finger related to a fall." "Patients finger continues to be black around the nail bed no redness or warmth noted to site. Nail remains intact at this time." R1's Incident Review and Analysis report dated 9/15/20, identified R1 had fallen from her wheelchair on 9/15/20. No assessment of the cause of R1's fall from the chair was completed. The form identified R1 was sent to the emergency room for evaluation due to a head wound. R1's hospital Admission History and Physical dated 9/15/20, included, "Patient was found on floor in bedroom and then seemed to throw herself on floor at nursing station. She has been agitated/verbally upset at times. Wanting to go upstairs." The results from a CT of head noted an acute nondisplaced fracture of the left	2 830		

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 24	2 830		

posterial parietal bone (skull fracture). R1's hospital discharge summary identified R1 had sustained a closed skull fracture and a fracture of her right hand 2nd finger which would be splinted before returning to the nursing home. The finger fracture was in a stage of healing, identifying it had happened in the past. The facility identified an injury to R1's right index finger in the the progress notes on 8/30/20. However, this was not assessed by a physician or x-rayed until hospitalized on 9/15/20.

When interviewed on 9/24/20, at 1:00 p.m. NA-B stated R1 had fallen from bed a lot and from her wheel chair, she was constantly trying to stand up and required one on one attention or she would fall. NA-B stated they did not have time to do one on ones with R1. NA-B did not know of any interventions that helped R1 with the agitation and trying to stand up all the time, other than to sit with her one on one, winch was not possible as other residents required care too.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated R1 had fallen frequently, she would scream and throw herself from bed. The only interventions she knew of was to have the bed in the low position and mats on the floor so when R1 did this she wouldn't be injured. NA-C remembered R1 had a large swollen egg sized area on her forehead and had broken her finger, but did not know when this occurred.

When interviewed on 9/24/20, at 3:07 p.m. R1's guardian stated they were concerned about R1 sustaining a fractured finger that went undiagnosed for so long.

When interviewed on 9/24/20, at 3:45 p.m. licensed practical nurse (LPN)-B stated R1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 25 constantly throwing herself off the bed and threatening to throw herself off the bed. There was not enough staff to do one on ones and supervision with R1. LPN-A was unable to find any assessment of R1's falls for pattern or to determine why she was falling. LPN-A stated it was R1's behaviors, but was unable to find any assessment of R1's behaviors to determine why she was, "throwing herself," out of bed. When interviewed on 9/28/20, at 10:10 a.m. the director of nursing (DON) stated they did not have a good system for when someone falls and they are trying to improve this process. The nurse should fill out an Incident Review and Analysis after each fall. The DON was only able to find 4 of these for R1's falls, which were for the falls sustained on 7/14/20, 7/31/20, 8/1/20, and 9/15/20. The DON did not know why this assessment had not been filled out for any of the other falls R1 sustained. R1 had behavioral issues and really required one on one attention, which they were unable to provided. The DON was unable to provide any assessment to determine if there was a pattern to R1's falls, and what interventions may assist R1 with her anxiety/behaviors that led to her falling so frequently. No assessment had been completed of R1's behaviors to determine interventions that may help. R4's significant change MDS dated 8/27/20, included severe cognitive impairment with a diagnosis of dementia with behavioral disturbance. R4 required extensive assist for bed mobility and dressing and total staff assistance for transfer, toileting, and personal hygiene. R4 was totally incontinent of bladder and rejected	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 26 cares 1-3 times during the assessment period. R3 had 1 fall without injury since prior assessment. R4's fall CAA included, "Resident triggers for falls r/t having impaired balance, history of falls, and psychotropic medication use. Resident has declined in both mobility and cognitive functions. She has recently enrolled in hospice for end of life cares. Has increased risk of falls r/t daily use of hypoglycemic, antihypertensive, diuretic, narcotic, and psychotropic medications. She is incontinent of bowel and bladder. She has had a recent fall from bed. Plan to continue to monitor for safety and keep call light within reach." R4's care plan dated 6/26/20 indicated, "Fall risk related to [blank]. Staff were directed, "Bed in lowest position. Call light within reach; fall mat. Follow PT and OT instruction for mobility function." The most recent intervention, "Ambulate to dining room with FWW [front wheel walker] support with CGA [contact guard assist] 120 ft [feet] x1 [with 1 staff] with FWW support" was added 7/22/20. No additional updates had been made. R4's nursing assistant Care Sheet included, "Assist of 2 w/ [with] Hoyer [mechanical lift]; Does not ambulate; fall mat; call light within reach." R4's progress note dated 8/26/20, at 10:51 p.m. included, "At 7:35 pm nurse aide found resident lying on floor next to bed. Resident appeared agitated/anxious and continued to try and stand/yell at staff. Resident swinging arms at staff when trying to position Hoyer [mechanical lift] sling so resident assisted back up into bed with Ax2 [assist of 2 staff]. Call light was within reach; fall mat was in place next to bed; bed was in	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 27	2 830		

lowest position; room was clear of clutter and well lit." "Resident received PRN [as needed] Seroquel [antipsychotic] for increased agitation/anxiety and was asleep within the following hour. Hospice, ADON [assistant director of nursing], and emergency contact were all notified. Writer and emergency contact talked about in-facility family visits in hospices [sic] to ease resident's anxiety/agitation and emergency contact thought it would be worth a try; Emergency contact is going to try and stop for a visit tomorrow."

When interviewed on 9/28/20, at 10:00 a.m. registered nurse (RN)-A stated there was no incident report or post fall follow-up report on R4's fall. R4's care plan was incorrect about walking R4, as she is no longer able to ambulate.

When interviewed on 9/28/20, at 11:35 a.m. family member (FM)-B stated they had not been allowed to visit related to COVID and was concerned about R4's falls. FM-B stated R4 would not be able to see them out her window for a visit. No one had spoken to them about possibly visiting to decrease anxiety.

When interviewed on 9/28/20, at 12:35 p.m. LPN-D stated R4 had fallen a couple times, rolling from bed. They put a mat on the floor next to the bed and make sure R4 has her call light in reach. LPN-D stated R4 would not know how to use the call light and was unsure why that was an intervention.

When interviewed on 9/28/20, at 3:05 p.m. RN-A stated, R4 was to have increased family window visits after this fall to aide in preventing more falls. The DON stated, the interdisciplinary team should meet after each fall, update care sheets and care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 28	2 830		

plan, and communicate the change, but the increased family visits had not been communicated to the family or added to R4's care plan. The facility was behind in updating care plans.

R3's admission MDS dated 8/15/20, included moderate cognitive impairment with diagnoses 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 risk 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 29	2 830		

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 and free from falls." Staff were directed to, Answer call light promptly, use a mechanical lift for transfers, follow therapy instructions, call light in reach, proper footwear, ensue frequently used items were in reach.

R3's progress note dated 8/10/20, at 9:31 p.m. included, "Writer was called into room when aid walked in and saw resident laying prone on the floor. Resident was next to wheelchair and was eating supper. Aid, ADON and writer helped resident up using hoyer [mechanical] lift. Resident states that he was eating and his spoon dropped and he went to go catch it and fell out of his wheelchair. Resident states he hit his nose on the chair that was next to the wheel chair."

R3's progress note dated 8/22/20, at 6:55 p.m. included, "Residents door was open and writer was at the medicine cart adjacent to the room." "Pt [patient] was attempting at self transfers and RN heard some sound that was apparently from his wheel chair and no sooner than he turned, he saw the resident fall to the floor."

R3's progress note dated 8/28/20, included, "Writer was called by aid to assist resident off the floor. Resident was on the ground on his bottom and had his hands holding onto side rail of bed. Resident was sitting crossed legged next to bed sitting up. Resident states he was getting out of his wheel chair to get into bed. Resident then slipped off the bed and onto his bottom next to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 30	2 830		

bed. Resident's vital signs were within normal limits. Resident was reminded to use his call light for all transfers."

R3's progress note dated 9/4/20, 10:32 p.m. included, R3 self transferred and was found sliding off edge of bed.

R3's progress note dated 9/11/20, included, "Resident was laying on back on the ground. Resident was holding handle gripper in hand and waiving it in the air. Residents wheelchair was right next to him with the breaks unlocked. Resident states he was chasing the cats out of his room and using the handle gripper to get them out of his way. Resident then fell out of wheelchair while doing this." "Resident was told there were no cats in this facility." There was no assessment of R3's belief there were cats in his room, even though R3 had not had hallucinations or delusions at the time of the comprehensive assessment.

When interviewed on 9/28/20, at 10:31 a.m. LPN-C stated other than what was already in the care plan, no new interventions were added after any of these falls. LPN-C was unable to provide any post fall assessment for any of these falls. The facility had not assessed each fall to determine root cause, nor place interventions to prevent the falls from happening again. R3 had increased confusion after admission, which was not assessed other than to offer psych services, which the family declined. Normally, the interdisciplinary team would assess each fall the next day and place new interventions based upon that assessment, but this had not been done for R3.

When interviewed on 9/28/20, at 11:44 a.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 830	Continued From page 31 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 prevent serious injury from falls. 6. Care plans will be updated to reflect fall interventions." 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. 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 consistency, small bites thorough mastication	2 830		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 32 (chewing), swallow bites before taking another bite/sip, slow pacing, single sips, alternate between liquids/solids. The report indicated further analysis would be required to determine if R10 would be appropriate 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. R10's care plan dated 4/1/20, included, risk for nutritional alteration related to coughing during meals; had diet restrictions which included NDD2 [National Dysphagia Diet, level 2- meats are to be ground or are minced no larger than 1/4 inch pieces, they are moist, with some cohesion] diet and could have requested puree. Staff were directed to monitor, document, and report to the physician as needed for signs and symptoms of swallowing problems. R10's undated nursing assistant Care Guide included mechanical soft diet with pureed meat. R10's Nutrition Evaluation dated 4/16/20, identified a mechanical soft diet with pureed meat. Speech therapy recommended to, "have all meats ground, unless resident request pureed for preference." R10's Oral/Dental Evaluation dated 7/14/20, indicated R10 had full upper and lower dentures. During observation on 9/25/20, at 12:42 p.m. R10 was observed to be coughing while eating. At 12:47 p.m. it was noted R10 was eating a regular hamburger patty on a bun. R10 stated it was hard to eat because she did not have her dentures in. She had requested the regular patty	2 830		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 830	Continued From page 33 as the staff had grilled out the burgers and she desired one. R10 continued to cough while eating, no one checked to see if she was alright, nor did anyone bring her dentures. R10's lunch tray ticket included, "Mechanical soft texture and to provide ground grilled hamburger, potato salad, no raw veggies, beans, shredded lettuce." When interviewed on 9/25/20, at 1:06 p.m. dietary aide (DA)-A stated residents who require a mechanical soft diet should have been provided with ground meat. R10 coughing is something she normally does while eating. When interviewed on 9/25/20, at 1:12 p.m. cook (CK)-A stated, a mechanical soft diet should have ground meat, no bread or hard vegetables. The cook is the person responsible to ensure the correct diet is served. When interviewed on 9/25/20, at 1:21 p.m. NA-F stated R10 does cough at meals, she was unaware R10 did not have dentures in. NA-F stated if someone is coughing like that, they should go get a nurse to assess if no nurse was in the dining room. When interviewed on 9/25/20, at 1:34 p.m. R10 stated she normally gets a ground burger, but today got a regular whole burger as they were grilling them. R10 stated she normally wore her dentures, but forgot them today. Staff sometimes have to remind her to put them in or help her with them. At 1:39 p.m. R10 was coughing and NA-H asked her if she was ok. When interviewed on 9/25/20, at 3:06 p.m. RN-B stated resident's diets could be upgraded if they	2 830		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 830	Continued From page 34	2 830		

wished for an upgrade, but would have to sign a risk versus benefits statement. R10 did not have a risk versus benefits statement signed nor was she given the risks of choking when provided with a regular hamburger today.

When interviewed on 9/25/20, at 3:08 p.m. Cook-A stated they have a file of each resident who had signed a risk versus benefits statement for a diet upgrade, then if they ask for an upgrade they can provide it. R10 did not have one of these. R10 should have been provided the ground meat diet as ordered and not a regular hamburger.

R10's Diet Requisition Form provided by Cook-A and dated 3/31/20, had been completed by speech therapy and indicated R10 was to have a Mechanical Soft/Ground Meat NDD2 diet consistency and patient could downgrade to pureed food if desired.

When interviewed on 9/28/20, at 10:21 p.m. the registered dietician (RD) stated if a resident were coughing during a meal it should be reported to the DON, food service director and speech therapy. This had not been done for R10. The facility should not provide an upgraded texture diet without risks being explained to the resident and a form signed.

When interviewed on 9/28/20, at 2:37 p.m. the DON and RN-A stated it is important to provide the correct diet texture for residents with swallowing problems. A nurse should be notified if a resident is coughing.

R5's quarterly MDS dated 9/4/20, indicated no cognitive impairment with diagnoses including,

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 35 stroke, epilepsy. The MDS noted R5 had coughing and choking during meals or when swallowing medications during the assessment period. The MDS further indicated supervision, oversite, set up when eating and mechanically altered textures. 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. R5's Care Assessment Area Worksheet (CAA) dated 1/20/20, indicated R5 required a mechanically altered diet. There was no analysis completed, but was noted to proceed to care planning. R5's care plan dated 3/20/20, indicated R5 was at risk for nutritional alteration related to chronic pain front thorax and diet restriction for NDD3 diet. Staff were directed to monitor, document and report to physician for signs or symptoms of dysphagia when eating. R5's Progress note dated, 1/25/19, indicated her diet was changed to NDD3 by Speech therapy. R5's Nutritional Evaluation dated 9/4/20, identified a diet order for NDD3, Dysphagia Advanced diet level 3.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 830	Continued From page 36 R5's Care guide for staff indicated a regular diet and independent in dining room which is different from MDS 9/4/20, CAA 1/20/20, Medical Record, physician order and care plan. R5's lunch tray ticket included a diet order for Dysphagia Advanced diet (NDD3). The tray ticket further directed to provide chopped, grilled hamburger on bun, potato salad, no raw vegetables, backed beans, no bacon, shredded lettuce, soft ice cream and milk. During an observation on 9/25/20, at 12:50 p.m. R5 sat alone at a table and was noted to cough while she ate her meal. R5's plate contained a whole hamburger with a wedge of lettuce that covered the burger on a bun and potato chips. There were various staff throughout the dining area including nursing and dietary, but no one stopped to see why R5 was coughing. At 12:52 p.m. R5 was observed to be shaking and asked for someone get a nurse because she was having a seizure. Staff came and brought R5 out of the dining room. When interviewed on 9/25/20, at 1:06 p.m. DA-A stated R5 should have received ground meat, beans, potato salad, soft cooked vegetables. R5 should not have had a bun, the burger should have been ground and should not have received potato chips or whole leaf lettuce. When interviewed on 9/25/20, at 1:10 p.m. R5 stated she has occasional seizure that are like, "spells," and has no diet restrictions. When interviewed on 9/25/20, at 1:12 p.m. Cook-A stated the facility provided NDD3, NDD2 and pureed textures. A mechanical diet should have ground meat, no bread or hard vegetables.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 830	Continued From page 37 For the noon meal provided on 9/25/20, a mechanical texture should have included, no bun, ground hamburger, potato salad and beans. It was the cook's responsibility to make sure a resident is getting the appropriate texture. When interviewed on 9/25/20, at 1:21 p.m. NA-F stated staff should check on residents who are coughing and should get a nurse. R5 should have received the correct diet and did not know who gave her the wrong diet. When interviewed on 9/25/20, at 1:40 p.m. Dietary Aide-A reported both dietary and nursing aides deliver meal trays. When interviewed on 9/25/20, at 3:06 p.m. RN-B stated a resident is ok to be provided an upgraded texture if a risk and benefit form had been signed. The resident should be given the order from the physician if there is no signed risk and benefit form. R5 did not have a signed form. On 9/25/20 at 3:08 p.m. Cook-A- stated R5 should have received the ordered diet, but did not, the Cook is responsible for providing the correct diet. The facility Refusal of Care/Interventions, Risk and Benefits policy dated 9/11, identified a resident would be informed of the risk and benefits of necessary care and given the opportunity regarding their decision in the plan of care. The resident would be approached 2-3 times and if resident continued to refuse, documentation should be made on the Refusal of Care Interventions Risk and Benefits and reviewed quarterly. The National Dysphagia Diet indicated NDD2 as	2 830		

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2 830	Continued From page 38 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 soft, well-cooked vegetables. Vegetables should be less than 1/2 inch and should be easily mashed with a fork. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours,	2 905		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 905	Continued From page 39 including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. 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. Findings include: R4's significant change Minimum Data Set (MDS) dated 8/27/20, included severe cognitive impairment with a diagnosis of dementia. R4 required extensive assist for bed mobility and total staff assistance for transfer. R4 was at risk for pressure ulcer development, but did not have a current pressure ulcer. R4's pressure ulcer Care Area Assessment (CAA) dated 8/28/20 included, "Resident triggers for pressure r/t [related to] need for assistance with bed mobility and bowel and bladder incontinence. Resident is at risk for skin break down r/t cognitive impairment, dx [diagnosis] of HTN [hypertension] and Type 2 DM [diabetes] and daily use of ASA [aspirin] and Coumadin [blood thinner]. She is incontinent of bowel and bladder. Resident noted to have scabbed area over skin tear on LLE [lower left extremity]. Skin otherwise intact. Preventative skin measures in place with toileting and repositioning q [every] 2 hours, pressure redistribution cushion to wheelchair and mattress to bed, routine skin cares q [every] AM [morning] and HS [night], and	2 905		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 905	Continued From page 40 weekly skin inspections." R4's care plan dated 6/26/20 included, "Potential alteration in skin integrity." Staff were directed to, "Monitor skin integrity daily. Weekly skin inspection by nurse. Treatment to open areas per order. Pressure redistribution mattress to bed. Pressure redistribution cushion to wheelchair, chair." Care plan interventions updated 9/1/20. R4's care plan further indicated, "Alteration in mobility related to end of life" with interventions: "Dependent with bed mobility: A1-2 [assist of 1-2 staff]. Maxi lift (Hoyer) [mechanical lift] with transfers. Turn and reposition Q2H [every 2 hours]." Additionally R4's care plan specified, "Alteration in comfort," with an intervention dated 9/8/20: "Position q2hrs [every 2 hours] and PRN [as needed] with pillows for comfort." R4's nursing assistant Care Sheet included, "Assist of 2 w/ [with] Hoyer [mechanical lift]; does not ambulate." The care sheet did not direct staff on how often to assist R4 with turning and repositioning. A Hospice Facility Visit progress note dated 9/3/20 included, "Does verbalize some discomfort to bottom." During continuous observation on 9/25/20, starting at 10:25 a.m. R4 was attempting to adjust herself in the wheelchair, but was not able to effectively adjust herself. At 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. The 2 staff members offered to recline R4's wheelchair. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to reposition occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

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2 905	Continued From page 41	2 905		

sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining room. At 1:55 p.m. nursing assistant (NA)-F and 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 terrible 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.

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 staff 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."

SUGGESTED METHOD OF CORRECTION:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 905	Continued From page 42 The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary repositioning treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide incontinence care timely, and failed to reassess continence status after a significant change for 1 of 3 residents (R3) reviewed for incontinence. Findings include: R4's admission Minimum Data Set (MDS) dated 6/29/20, included, moderate cognitive impairment with diagnoses including diabetes, dementia and arthritis. R4 required extensive assistance with	2 920		

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	00568	A. BUILDING: _____ B. WING _____	C 09/28/2020

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2 920	Continued From page 43 toileting and limited assistance with personal hygiene. R4 was not on a toileting program and was occasionally incontinent of urine (less than 7 times during the assessment period). R4's incontinence Care Area Assessment (CAA) dated 7/1/20 indicated, "Resident triggers for urinary incontinence r/t [related to] need for assistance with toilet use and bladder incontinence." "She is in PT [physical therapy] and OT [occupational therapy] at this time with the goal of returning to the community. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode." R4's significant change MDS dated 8/27/20, included severe cognitive impairment, was totally dependent upon staff for toileting and personal hygiene and was always incontinent of urine. R4's incontinence CAA dated 8/28/20 included, "Resident triggers for urinary incontinence r/t toilet use and bladder incontinence. Resident has declined in both mobility and cognitive function. She has recently enrolled in hospice for end of life cares. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode." R4's only Bowel and Bladder assessment in the medical record was dated 6/24/20, and indicated R4 was continent of bowel and bladder. R4's care plan dated 6/26/20, included, "Alteration with elimination." Staff were directed to, "Assist of 1 with toileting." The care plan had	2 920		

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2 920	Continued From page 44	2 920		

not been updated since 6/26/20, even though the 8/27/20, MDS noted a decline in urinary incontinence to totally incontinent and an increase in assistance needs for toileting and personal hygiene.

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.

During continuous observation on 9/25/20, starting at 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to provide incontinence cares occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. LPN-D then brought R4 to the dining room. Incontinence cares were not provided. At 1:58 p.m. NA-F and NA-B assisted R4 into bed and changed R4's visibly wet brief.

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 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

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2 920	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 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 (21) days.	2 920		

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21810	Continued From page 46	21810		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 1 resident (R7) reviewed for dignity concerns. Findings include: R7's admission Minimum Date Set (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. 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. R7's care plan dated 7/29/20, included, R7 required assistance for, "Bathing with max to dependent assist, dressing with max assist, personal hygiene set-up with minimal assist,	21810		

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21810	Continued From page 47 occasionally incontinent, and requires assistance with toilet use." 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 night shift is customarily staffed with two NA's and 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 state there is insufficient staff to meet the individual needs of each resident. The morale among staff and residents is low because of this. R7 being incontinent due to not being able to get to her timely is a dignity issue.	21810		

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21810	Continued From page 48 R7's call light response time logs dated from 9/22/20, at 3:51 a.m. to 9/28/20, 9:25 a.m. showed the call light was engaged 51 times over the seven day period. Of the 51 call light alerts initiated, 11 (or 21.5%) of these alerts took over 15 minutes to receive a response. Seven (or 14%) of these alerts took longer than 20 minutes to receive a response. During a phone call interview on 9/28/20, at 3:30 p.m. the administrator stated they do not have a staffing or facility assessment in place to assist in determining staffing needs at this time. The administrator stated current staffing rations include one staff member for every ten residents. "More comradery and better communication," was needed among the staff. These measures would improve care. The administrator stated that they are working on this initiative. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and revise procedures to ensure residents recieve the care they need in a timely fashion. It could also address other residents that may be at risk for the same concern. The facility could educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

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F 000	INITIAL COMMENTS On 9/24/20, 9/25/20 and 9/28/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5090056C at F689 H5090057C at F677 and F725 H5090059C at F677, F686 and F725 The following complaints were found to be unsubstantiated: H5090055C and H5090058C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		

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

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 1 resident (R7) reviewed for dignity concerns.	F 550		

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F 550	Continued From page 2 Findings include: R7's admission Minimum Date Set (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. 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. R7's care plan dated 7/29/20, included, R7 required assistance for, "Bathing with max to dependent assist, dressing with max assist, personal hygiene set-up with minimal assist, occasionally incontinent, and requires assistance with toilet use." 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.	F 550		

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F 550	Continued From page 3	F 550		

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 and 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 state there is insufficient staff to meet the individual needs of each resident. The morale among staff and residents is low because of this. R7 being incontinent due to not being able to get to her timely is a dignity issue.

R7's call light response time logs dated from 9/22/20, at 3:51 a.m. to 9/28/20, 9:25 a.m. showed the call light was engaged 51 times over the seven day period. Of the 51 call light alerts initiated, 11 (or 21.5%) of these alerts took over 15 minutes to receive a response. Seven (or 14%) of these alerts took longer than 20 minutes to receive a response.

During a phone call interview on 9/28/20, at 3:30 p.m. the administrator stated they do not have a staffing or facility assessment in place to assist in determining staffing needs at this time. The administrator stated current staffing rations include one staff member for every ten residents. "More comradery and better communication," was needed among the staff. These measures would improve care. The administrator stated that they are working on this initiative.

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F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to issue a written bed-hold notice upon transfer to the hospital for 1 of 3 residents (R1) reviewed for hospitalizations. Findings include:	F 625		

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F 625	Continued From page 5 R1's admission Minimum Data Set (MDS) dated 5/20/20, indicated R1 was admitted to facility on 5/14/20 with a discharge assessment-return anticipated MDS dated, 9/16/20. R1's progress note dated 9/16/20, at 6:24 p.m. included, R1 was transferred to the hospital and a full report was given to the police and transport teams. However a bed hold notice was not found in R1's medical record. When interviewed on 9/24/20, at 3:07 p.m. R1's guardian reported she had not been provided a bed hold notification and was unaware of the possibility to hold the bed for R1. When interviewed on 9/28/20, at 2:09 p.m. the interim director of nursing (DON) verified a written bed hold notice was not completed for R1. Facility policy titled, Transfer or Discharge, Emergency revised on 08/2018, indicated under bullet number 4: "The business office is responsible for: b. Informing the resident, or his or her representative (sponsor) of our facility's readmission appeal rights, bed-holding policies, ect."	F 625		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide incontinence	F 677		

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PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

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F 677	Continued From page 6 care timely, and failed to reassess continence status after a significant change for 1 of 3 residents (R3) reviewed for incontinence. Findings include: R4's admission Minimum Data Set (MDS) dated 6/29/20, included, moderate cognitive impairment with diagnoses including diabetes, dementia and arthritis. R4 required extensive assistance with toileting and limited assistance with personal hygiene. R4 was not on a toileting program and was occasionally incontinent of urine (less than 7 times during the assessment period). R4's incontinence Care Area Assessment (CAA) dated 7/1/20 indicated, "Resident triggers for urinary incontinence r/t [related to] need for assistance with toilet use and bladder incontinence." "She is in PT [physical therapy] and OT [occupational therapy] at this time with the goal of returning to the community. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode." R4's significant change MDS dated 8/27/20, included severe cognitive impairment, was totally dependent upon staff for toileting and personal hygiene and was always incontinent of urine. R4's incontinence CAA dated 8/28/20 included, "Resident triggers for urinary incontinence r/t toilet use and bladder incontinence. Resident has declined in both mobility and cognitive function. She has recently enrolled in hospice for end of life cares. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 7	F 677		

current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's only Bowel and Bladder assessment in the medical record was dated 6/24/20, and indicated R4 was continent of bowel and bladder.

R4's care plan dated 6/26/20, included, "Alteration with elimination." Staff were directed to, "Assist of 1 with toileting." The care plan had not been updated since 6/26/20, even though the 8/27/20, MDS noted a decline in urinary incontinence to totally incontinent and an increase in assistance needs for toileting and personal hygiene.

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.

During continuous observation on 9/25/20, starting at 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to provide incontinence cares occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. LPN-D then brought R4 to the dining room. Incontinence cares were not provided. At 1:58 p.m. NA-F and NA-B assisted R4 into bed and changed R4's visibly wet brief.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. 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, 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."	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 9 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide repositioning timely for 1 of 3 residents (R4) reviewed who were at risk of developing pressure ulcers. Findings include: R4's significant change Minimum Data Set (MDS) dated 8/27/20, included severe cognitive impairment with a diagnosis of dementia. R4 required extensive assist for bed mobility and total staff assistance for transfer. R4 was at risk for pressure ulcer development, but did not have a current pressure ulcer. R4's pressure ulcer Care Area Assessment (CAA) dated 8/28/20 included, "Resident triggers for pressure r/t [related to] need for assistance with bed mobility and bowel and bladder incontinence. Resident is at risk for skin break down r/t cognitive impairment, dx [diagnosis] of HTN [hypertension] and Type 2 DM [diabetes]	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 10	F 686		

and daily use of ASA [aspirin] and Coumadin [blood thinner]. She is incontinent of bowel and bladder. Resident noted to have scabbed area over skin tear on LLE [lower left extremity]. Skin otherwise intact. Preventative skin measures in place with toileting and repositioning q [every] 2 hours, pressure redistribution cushion to wheelchair and mattress to bed, routine skin cares q [every] AM [morning] and HS [night], and weekly skin inspections."

R4's care plan dated 6/26/20 included, "Potential alteration in skin integrity." Staff were directed to, "Monitor skin integrity daily. Weekly skin inspection by nurse. Treatment to open areas per order. Pressure redistribution mattress to bed. Pressure redistribution cushion to wheelchair, chair." Care plan interventions updated 9/1/20. R4's care plan further indicated, "Alteration in mobility related to end of life" with interventions: "Dependent with bed mobility: A1-2 [assist of 1-2 staff]. Maxi lift (Hoyer) [mechanical lift] with transfers. Turn and reposition Q2H [every 2 hours]." Additionally R4's care plan specified, "Alteration in comfort," with an intervention dated 9/8/20: "Position q2hrs [every 2 hours] and PRN [as needed] with pillows for comfort."

R4's nursing assistant Care Sheet included, "Assist of 2 w/ [with] Hoyer [mechanical lift]; does not ambulate." The care sheet did not direct staff on how often to assist R4 with turning and repositioning.

A Hospice Facility Visit progress note dated 9/3/20 included, "Does verbalize some discomfort to bottom."

During continuous observation on 9/25/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 11	F 686		

starting at 10:25 a.m. R4 was attempting to adjust herself in the wheelchair, but was not able to effectively adjust herself. At 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. The 2 staff members offered to recline R4's wheelchair. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to reposition occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining room. At 1:55 p.m. nursing assistant (NA)-F and 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 terrible 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.

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 staff for repositioning." The policy further instructs,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12 "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."	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 3 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 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: R1's quarterly Minimum Data Set (MDS) dated 8/20/20, included, severe cognitive impairment with diagnoses including TBI (traumatic brain injury) and dementia. R1 required extensive	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

assistance with most activities of daily living (ADL's) and did not ambulate. R4 had 2 or more falls with injury since the prior assessment. R1 had a discharge MDS dated 9/16/20.

R1's falls Care Area Assessment dated 5/22/20, included, "Resident triggers for falls r/t [related to] having impaired balance and daily psychotropic medication use. Resident has decreased mobility following hospitalization for a UTI [urinary tract infection] and increased behaviors. Resident was involved in a MVA [motor vehicle accident] last November and suffered multiple major injuries including but not limited to: skull fractures, TBI, rib fractures, and wrist fractures." "Resident is at increased risk for falls r/t cognitive impairment, agitation, and daily use of psychotropic, anticonvulsant, antihypertensive, and benzodiazepine medications. She is incontinent of bowel and bladder. She does not have a history of falls prior to admission and has not had any falls since admission. Resident was moved to a room closer to the nurses station for safety. Plan to continue to monitor for safety, keep call light in reach, and follow therapy recommendations." The CAA indicated falls would be addressed in the care plan.

R1's admission Fall Review Evaluation dated 5/19/20, included a check list of risk factors for falls as identified in the 5/22/20 CAA. However, there was no analysis of fall risk factors or identification of interventions that may mitigate or reduce the chance of R1 falling.

R1's care plan dated 9/2/20, included, "Fall risk AEB [as evidenced by] multiple falls since admission related to lack of safety awareness secondary to TBI and Dementia with behavioral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

disturbances." The goal for R1 was listed as, "Resident will be safe and free from serious injury should incident occur." Staff were directed to, use one assist for transfers with a standing lift. Place bed on low position. Have fall mats on both sides of bed. Leave door open at all times unless providing cares. Use a tilt-in-space wheel chair for comfort. To be visually supervised when in wheel chair. Provide one on one care, such as taking outside and wheeling her down the hall.

R1's Action Summary dated 7/1/20 to 9/28/20, identified R1 had fallen 17 times on 7/14/20, 7/31/20, 8/1/20, 8/5/20, 8/6/20, 8/11/20, 8/12/20, 8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20, 8/21/20, 8/29/20, 9/3/20, 9/14/20 and 9/15/20. In addition, R1's progress notes dated 7/29/20 and 8/30/20 identified she had fallen, but these were not included on the Action Summary. There were no progress notes or incident reports for the falls identified on the Action Summary which were dated 8/11/20, 8/12/20 (2 falls), 8/19/20, or 9/14/20. Twelve of the falls were identified in the progress notes as being a fall from bed onto the mat next to the bed. These were on 7/31/20, 8/5/20, 8/6/20, 8/16/20 - three times, 8/21/20- 3 times, 8/29/20, 8/30/20, and 9/3/20. 2 falls were identified from a wheel chair on 8/29/20 and 9/15/20. 1 fall from recliner on 7/29/20. There was no documentation to determine the circumstances of the falls that occurred on 7/14/20, 8/11/12, 8/11/20, 8/12/20, 8/19/20 or 9/14/20.

R1's Incident Review and Analysis dated 7/20/20, included, R1 was found on the floor on 7/14/20. Incident Analysis included, "Staff was walking by resident's room and saw resident lying on the floor." "Resident with lack of safety awareness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

which contributes to resident's fall risks due to diagnosis of unspecified TBI w/o loss of consciousness; Dementia with behavioral disturbance." The follow-up/intervention section listed: proper footwear, evaluation by PT/OT (physical therapy/occupational therapy), bed in lowest position and soft touch call light. Resident to be visually supervised when in wheelchair. Provide tilt-in-space wheelchair with the ability to recline resident when in chair to provide ore comfort. Staff providing 1:1 (one on one) care such as taking her outside and wheeling her down the hall. "Resident with behaviors and often times heard yelling. Resident requires 1:1 attention to staff and to redirect and provide reassurance. Resident is at high fall risk due to lack of safety awareness due to TBI and dementia. Resident also experiences agitation and restlessness and could be the reason of resident's self transferring to get staff's attention to tend to her." These interventions were added to the care plan.

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."

R1's progress note dated 7/31/20, included, "At 8:40 PM writer heard resident calling out from her room and found resident on the floor laying next to her bed." Abrasions were noted to both knees. There was no assessment of this fall. Interventions added were, "All staff will make sure resident's bedroom door is not closed completely and will keep bathroom light on when room is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

dark." Keeping the bathroom light on when the room is dark was not added to the care plan.

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 had knees on ground and torso was still in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

bed. Resident was confused and wanted to leave facility."

R1's progress note dated 8/16/20, at 10:35 p.m. included, "Aid called nurse in to find resident sitting on floor with arms on the bed. Resident was wanting to leave facility."

R1's progress note dated 8/16/20, at 10:40 p.m. included, "Resident was on floor sliding off her bed. Resident had just fallen previous to this but slid out of her bed. Resident was waning [sic] to leave facility and calling out to staff "someone get me out of here."

R1's progress note dated 8/21/20, included, "Writer observed resident sitting on floor x 3 on mat next to bed this shift. No injuries noted. Bed at lowest position. Asked resident what happened and resident stated, "Trying to get out of here."

R1's progress note dated 8/29/20, included, "At 2:15 PM writer heard resident yelling from lobby. Writer found resident laying on the floor next to her W/C [wheel chair] yelling "Ow my head." Writer found 1" [inch] x 1.5" abrasion to resident's forehead. Resident was wearing appropriate footwear, foot pedals in place on W/C, and no incontinence noted. Resident unable to describe to writer what happened except that "I fell and hit my head." Cool wet towel was applied to forehead. Then found an abrasion on her knee also.

R1's progress note dated 8/30/20, included, "Writer heard repeated yelling out from resident's room and found resident on the floor next to her bed. Bed was in lowest position, call light within

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

reach, fall mats in place both sides of bed, and resident not incontinent."

R1's progress note dated 8/30/20, noted a bruise on right index finger and a scrape on her head. There was no incident report or assessment to determine when these injuries occurred.

R1's progress note dated 8/31/20, included, the physician had been updated on bruise to right index finger.

R1's progress note dated 9/2/20, included, "Ice to sore right finger."

R1's treatment record identified staff were to monitor right index finger related to a fall. However, it did not identify which fall caused this injury.

R1's progress note dated 9/3/20, included, "Writer heard resident yelling from her room and when writer arrived resident was sitting on the floor next to her bed yelling, "Help me get back up. Bed was in lowest position with fall mats in place and call light in reach."

Even though R1 had fallen from bed 13 times, there was no comprehensive assessment to determine the reason R1 was falling from bed, any pattern in time of day or situation, or to determine why the current interventions were not working to prevent further falls.

R1's progress note dated 9/10/20, included, "Monitor right index finger related to a fall." "Nail bed and part of finger appears black."

R1's progress note dated 9//13/20, identified to,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

"Monitor right index finger related to a fall." "Patients finger continues to be black around the nail bed no redness or warmth noted to site. Nail remains intact at this time."

R1's Incident Review and Analysis report dated 9/15/20, identified R1 had fallen from her wheelchair on 9/15/20. No assessment of the cause of R1's fall from the chair was completed. The form identified R1 was sent to the emergency room for evaluation due to a head wound.

R1's hospital Admission History and Physical dated 9/15/20, included, "Patient was found on floor in bedroom and then seemed to throw herself on floor at nursing station. She has been agitated/verbally upset at times. Wanting to go upstairs." The results from a CT of head noted an acute nondisplaced fracture of the left posterial parietal bone (skull fracture). R1's hospital discharge summary identified R1 had sustained a closed skull fracture and a fracture of her right hand 2nd finger which would be splinted before returning to the nursing home. The finger fracture was in a stage of healing, identifying it had happened in the past. The facility identified an injury to R1's right index finger in the the progress notes on 8/30/20. However, this was not assessed by a physician or x-rayed until hospitalized on 9/15/20.

When interviewed on 9/24/20, at 1:00 p.m. NA-B stated R1 had fallen from bed a lot and from her wheel chair, she was constantly trying to stand up and required one on one attention or she would fall. NA-B stated they did not have time to do one on ones with R1. NA-B did not know of any interventions that helped R1 with the agitation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

and trying to stand up all the time, other than to sit with her one on one, winch was not possible as other residents required care too.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated R1 had fallen frequently, she would scream and throw herself from bed. The only interventions she knew of was to have the bed in the low position and mats on the floor so when R1 did this she wouldn't be injured. NA-C remembered R1 had a large swollen egg sized area on her forehead and had broken her finger, but did not know when this occurred.

When interviewed on 9/24/20, at 3:07 p.m. R1's guardian stated they were concerned about R1 sustaining a fractured finger that went undiagnosed for so long.

When interviewed on 9/24/20, at 3:45 p.m. licensed practical nurse (LPN)-B stated R1 was constantly throwing herself off the bed and threatening to throw herself off the bed. There was not enough staff to do one on ones and supervision with R1. LPN-A was unable to find any assessment of R1's falls for pattern or to determine why she was falling. LPN-A stated it was R1's behaviors, but was unable to find any assessment of R1's behaviors to determine why she was, "throwing herself," out of bed.

When interviewed on 9/28/20, at 10:10 a.m. the director of nursing (DON) stated they did not have a good system for when someone falls and they are trying to improve this process. The nurse should fill out an Incident Review and Analysis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21 after each fall. The DON was only able to find 4 of these for R1's falls, which were for the falls sustained on 7/14/20, 7/31/20, 8/1/20, and 9/15/20. The DON did not know why this assessment had not been filled out for any of the other falls R1 sustained. R1 had behavioral issues and really required one on one attention, which they were unable to provided. The DON was unable to provide any assessment to determine if there was a pattern to R1's falls, and what interventions may assist R1 with her anxiety/behaviors that led to her falling so frequently. No assessment had been completed of R1's behaviors to determine interventions that may help. R4's significant change MDS dated 8/27/20, included severe cognitive impairment with a diagnosis of dementia with behavioral disturbance. R4 required extensive assist for bed mobility and dressing and total staff assistance for transfer, toileting, and personal hygiene. R4 was totally incontinent of bladder and rejected cares 1-3 times during the assessment period. R3 had 1 fall without injury since prior assessment. R4's fall CAA included, "Resident triggers for falls r/t having impaired balance, history of falls, and psychotropic medication use. Resident has declined in both mobility and cognitive functions. She has recently enrolled in hospice for end of life cares. Has increased risk of falls r/t daily use	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

of hypoglycemic, antihypertensive, diuretic, narcotic, and psychotropic medications. She is incontinent of bowel and bladder. She has had a recent fall from bed. Plan to continue to monitor for safety and keep call light within reach."

R4's care plan dated 6/26/20 indicated, "Fall risk related to [blank]. Staff were directed, "Bed in lowest position. Call light within reach; fall mat. Follow PT and OT instruction for mobility function." The most recent intervention, "Ambulate to dining room with FWW [front wheel walker] support with CGA [contact guard assist] 120 ft [feet] x1 [with 1 staff] with FWW support" was added 7/22/20. No additional updates had been made.

R4's nursing assistant Care Sheet included, "Assist of 2 w/ [with] Hoyer [mechanical lift]; Does not ambulate; fall mat; call light within reach."

R4's progress note dated 8/26/20, at 10:51 p.m. included, "At 7:35 pm nurse aide found resident lying on floor next to bed. Resident appeared agitated/anxious and continued to try and stand/yell at staff. Resident swinging arms at staff when trying to position Hoyer [mechanical lift] sling so resident assisted back up into bed with Ax2 [assist of 2 staff]. Call light was within reach; fall mat was in place next to bed; bed was in lowest position; room was clear of clutter and well lit." "Resident received PRN [as needed] Seroquel [antipsychotic] for increased agitation/anxiety and was asleep within the following hour. Hospice, ADON [assistant director of nursing], and emergency contact were all notified. Writer and emergency contact talked about in-facility family visits in hospices [sic] to ease resident's anxiety/agitation and emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23	F 689		

contact thought it would be worth a try; Emergency contact is going to try and stop for a visit tomorrow."

When interviewed on 9/28/20, at 10:00 a.m. registered nurse (RN)-A stated there was no incident report or post fall follow-up report on R4's fall. R4's care plan was incorrect about walking R4, as she is no longer able to ambulate.

When interviewed on 9/28/20, at 11:35 a.m. family member (FM)-B stated they had not been allowed to visit related to COVID and was concerned about R4's falls. FM-B stated R4 would not be able to see them out her window for a visit. No one had spoken to them about possibly visiting to decrease anxiety.

When interviewed on 9/28/20, at 12:35 p.m. LPN-D stated R4 had fallen a couple times, rolling from bed. They put a mat on the floor next to the bed and make sure R4 has her call light in reach. LPN-D stated R4 would not know how to use the call light and was unsure why that was an intervention.

When interviewed on 9/28/20, at 3:05 p.m. RN-A stated, R4 was to have increased family window visits after this fall to aide in preventing more falls. The DON stated, the interdisciplinary team should meet after each fall, update care sheets and care plan, and communicate the change, but the increased family visits had not been communicated to the family or added to R4's care plan. The facility was behind in updating care plans.

R3's admission MDS dated 8/15/20, included moderate cognitive impairment with diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 risk 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25	F 689		

and free from falls." Staff were directed to, Answer call light promptly, use a mechanical lift for transfers, follow therapy instructions, call light in reach, proper footwear, ensue frequently used items were in reach.

R3's progress note dated 8/10/20, at 9:31 p.m. included, "Writer was called into room when aid walked in and saw resident laying prone on the floor. Resident was next to wheelchair and was eating supper. Aid, ADON and writer helped resident up using hoyer [mechanical] lift. Resident states that he was eating and his spoon dropped and he went to go catch it and fell out of his wheelchair. Resident states he hit his nose on the chair that was next to the wheel chair."

R3's progress note dated 8/22/20, at 6:55 p.m. included, "Residents door was open and writer was at the medicine cart adjacent to the room." "Pt [patient] was attempting at self transfers and RN heard some sound that was apparently from his wheel chair and no sooner than he turned, he saw the resident fall to the floor."

R3's progress note dated 8/28/20, included, "Writer was called by aid to assist resident off the floor. Resident was on the ground on his bottom and had his hands holding onto side rail of bed. Resident was sitting crossed legged next to bed sitting up. Resident states he was getting out of his wheel chair to get into bed. Resident then slipped off the bed and onto his bottom next to bed. Resident's vital signs were within normal limits. Resident was reminded to use his call light for all transfers."

R3's progress note dated 9/4/20, 10:32 p.m. included, R3 self transferred and was found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26 sliding off edge of bed. R3's progress note dated 9/11/20, included, "Resident was laying on back on the ground. Resident was holding handle gripper in hand and waiving it in the air. Residents wheelchair was right next to him with the breaks unlocked. Resident states he was chasing the cats out of his room and using the handle gripper to get them out of his way. Resident then fell out of wheelchair while doing this." "Resident was told there were no cats in this facility." There was no assessment of R3's belief there were cats in his room, even though R3 had not had hallucinations or delusions at the time of the comprehensive assessment. When interviewed on 9/28/20, at 10:31 a.m. LPN-C stated other than what was already in the care plan, no new interventions were added after any of these falls. LPN-C was unable to provide any post fall assessment for any of these falls. The facility had not assessed each fall to determine root cause, nor place interventions to prevent the falls from happening again. R3 had increased confusion after admission, which was not assessed other than to offer psych services, which the family declined. Normally, the interdisciplinary team would assess each fall the next day and place new interventions based upon that assessment, but this had not been done for R3. When interviewed on 9/28/20, at 11:44 a.m. the 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	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27 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 prevent serious injury from falls. 6. Care plans will be updated to reflect fall interventions." 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. 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 consistency, small bites thorough mastication (chewing), swallow bites before taking another bite/sip, slow pacing, single sips, alternate between liquids/solids. The report indicated further analysis would be required to determine if	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28 R10 would be appropriate 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. R10's care plan dated 4/1/20, included, risk for nutritional alteration related to coughing during meals; had diet restrictions which included NDD2 [National Dysphagia Diet, level 2- meats are to be ground or are minced no larger than 1/4 inch pieces, they are moist, with some cohesion] diet and could have requested puree. Staff were directed to monitor, document, and report to the physician as needed for signs and symptoms of swallowing problems. R10's undated nursing assistant Care Guide included mechanical soft diet with pureed meat. R10's Nutrition Evaluation dated 4/16/20, identified a mechanical soft diet with pureed meat. Speech therapy recommended to, "have all meats ground, unless resident request pureed for preference." R10's Oral/Dental Evaluation dated 7/14/20, indicated R10 had full upper and lower dentures. During observation on 9/25/20, at 12:42 p.m. R10 was observed to be coughing while eating. At 12:47 p.m. it was noted R10 was eating a regular hamburger patty on a bun. R10 stated it was hard to eat because she did not have her dentures in. She had requested the regular patty as the staff had grilled out the burgers and she desired one. R10 continued to cough while eating, no one checked to see if she was alright,	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29	F 689		

nor did anyone bring her dentures.

R10's lunch tray ticket included, "Mechanical soft texture and to provide ground grilled hamburger, potato salad, no raw veggies, beans, shredded lettuce."

When interviewed on 9/25/20, at 1:06 p.m. dietary aide (DA)-A stated residents who require a mechanical soft diet should have been provided with ground meat. R10 coughing is something she normally does while eating.

When interviewed on 9/25/20, at 1:12 p.m. cook (CK)-A stated, a mechanical soft diet should have ground meat, no bread or hard vegetables. The cook is the person responsible to ensure the correct diet is served.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated R10 does cough at meals, she was unaware R10 did not have dentures in. NA-F stated if someone is coughing like that, they should go get a nurse to assess if no nurse was in the dining room.

When interviewed on 9/25/20, at 1:34 p.m. R10 stated she normally gets a ground burger, but today got a regular whole burger as they were grilling them. R10 stated she normally wore her dentures, but forgot them today. Staff sometimes have to remind her to put them in or help her with them. At 1:39 p.m. R10 was coughing and NA-H asked her if she was ok.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated resident's diets could be upgraded if they wished for an upgrade, but would have to sign a risk versus benefits statement. R10 did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30	F 689		

a risk versus benefits statement signed nor was she given the risks of choking when provided with a regular hamburger today.

When interviewed on 9/25/20, at 3:08 p.m. Cook-A stated they have a file of each resident who had signed a risk versus benefits statement for a diet upgrade, then if they ask for an upgrade they can provide it. R10 did not have one of these. R10 should have been provided the ground meat diet as ordered and not a regular hamburger.

R10's Diet Requisition Form provided by Cook-A and dated 3/31/20, had been completed by speech therapy and indicated R10 was to have a Mechanical Soft/Ground Meat NDD2 diet consistency and patient could downgrade to pureed food if desired.

When interviewed on 9/28/20, at 10:21 p.m. the registered dietician (RD) stated if a resident were coughing during a meal it should be reported to the DON, food service director and speech therapy. This had not been done for R10. The facility should not provide an upgraded texture diet without risks being explained to the resident and a form signed.

When interviewed on 9/28/20, at 2:37 p.m. the DON and RN-A stated it is important to provide the correct diet texture for residents with swallowing problems. A nurse should be notified if a resident is coughing.

R5's quarterly MDS dated 9/4/20, indicated no cognitive impairment with diagnoses including, stroke, epilepsy. The MDS noted R5 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 31	F 689		

coughing and choking during meals or when swallowing medications during the assessment period. The MDS further indicated supervision, oversite, set up when eating and mechanically altered textures.

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.

R5's Care Assessment Area Worksheet (CAA) dated 1/20/20, indicated R5 required a mechanically altered diet. There was no analysis completed, but was noted to proceed to care planning.

R5's care plan dated 3/20/20, indicated R5 was at risk for nutritional alteration related to chronic pain front thorax and diet restriction for NDD3 diet. Staff were directed to monitor, document and report to physician for signs or symptoms of dysphagia when eating.

R5's Progress note dated, 1/25/19, indicated her diet was changed to NDD3 by Speech therapy.

R5's Nutritional Evaluation dated 9/4/20, identified a diet order for NDD3, Dysphagia Advanced diet level 3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32	F 689		

R5's Care guide for staff indicated a regular diet and independent in dining room which is different from MDS 9/4/20, CAA 1/20/20, Medical Record, physician order and care plan.

R5's lunch tray ticket included a diet order for Dysphagia Advanced diet (NDD3). The tray ticket further directed to provide chopped, grilled hamburger on bun, potato salad, no raw vegetables, backed beans, no bacon, shredded lettuce, soft ice cream and milk.

During an observation on 9/25/20, at 12:50 p.m. R5 sat alone at a table and was noted to cough while she ate her meal. R5's plate contained a whole hamburger with a wedge of lettuce that covered the burger on a bun and potato chips. There were various staff throughout the dining area including nursing and dietary, but no one stopped to see why R5 was coughing. At 12:52 p.m. R5 was observed to be shaking and asked for someone get a nurse because she was having a seizure. Staff came and brought R5 out of the dining room.

When interviewed on 9/25/20, at 1:06 p.m. DA-A stated R5 should have received ground meat, beans, potato salad, soft cooked vegetables. R5 should not have had a bun, the burger should have been ground and should not have received potato chips or whole leaf lettuce.

When interviewed on 9/25/20, at 1:10 p.m. R5 stated she has occasional seizure that are like, "spells," and has no diet restrictions.

When interviewed on 9/25/20, at 1:12 p.m. Cook-A stated the facility provided NDD3, NDD2 and pureed textures. A mechanical diet should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33	F 689		

have ground meat, no bread or hard vegetables. For the noon meal provided on 9/25/20, a mechanical texture should have included, no bun, ground hamburger, potato salad and beans. It was the cook's responsibility to make sure a resident is getting the appropriate texture.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated staff should check on residents who are coughing and should get a nurse. R5 should have received the correct diet and did not know who gave her the wrong diet.

When interviewed on 9/25/20, at 1:40 p.m. Dietary Aide-A reported both dietary and nursing aides deliver meal trays.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated a resident is ok to be provided an upgraded texture if a risk and benefit form had been signed. The resident should be given the order from the physician if there is no signed risk and benefit form. R5 did not have a signed form.

On 9/25/20 at 3:08 p.m. Cook-A- stated R5 should have received the ordered diet, but did not, the Cook is responsible for providing the correct diet.

The facility Refusal of Care/Interventions, Risk and Benefits policy dated 9/11, identified a resident would be informed of the risk and benefits of necessary care and given the opportunity regarding their decision in the plan of care. The resident would be approached 2-3 times and if resident continued to refuse, documentation should be made on the Refusal of Care Interventions Risk and Benefits and reviewed quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	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 soft, well-cooked vegetables. Vegetables should be less than 1/2 inch and should be easily mashed with a fork.	F 689		
F 725 SS=F	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 at §483.70(e). §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: (i) Except when waived under paragraph (e) of	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 35 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing to provide for the individualized care planned needs for 8 of 8 residents (R5, R7, R4, R1, R3, R8, R13 and R12), 12 of 15 staff (LPN-B, LPN-A, LPN-D, NA-D, NA-C, NA-J, NA-B, NA-F, NA-A, RN-A, HSK-A and NA-C) and 1 of 3 family members (FM)-A, reviewed for sufficient staffing. This had the potential to affect all 42 current residents. Findings include: R5's quarterly Minimum Data Set dated 9/4/20, included cognitively intact with diagnoses of stroke with paralysis or weakness on one side of the body and a seizure disorder. R5 required physical assistance from staff for toileting and bathing. R5 Care Assessment Worksheet (CAA) dated 1/20/20, included, R5 extensive assistance with activities of daily living (ADL) including bathing and toileting. R5's care plan updated 8/12/20, included, R5 needed assistance with toilet use and shower/bath with one assist twice a week on Sunday and Wednesday evenings with skin	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 36	F 725		

checks.

When interviewed on 9/24/20, at 12:23 p.m. licensed practical nurse (LPN)-A stated, R5 was not getting the timely care she needed with toileting, bathing and hygiene as there was not enough staff. R5 did complain about this.

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.

When interviewed on 9/24/20, at 3:22 p.m. a nursing assistant (NA)-D stated R5 required assistance with bathing and toileting, but often she had to wait for assistance as they do not have enough staff to get to everyone timely. Sometimes they have to skip R5's bath as they do not have enough 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.

R5's Grievance/Concern Report included, R5 did not receive a bath or shower on 7/22/20. NA-I stated, "R5's shower did not get done on Sunday evening due to time." NA-J stated, "R5's shower did not get done due to running out of time. Her bath requires two aids which [NA-I] and I were the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 37	F 725		

only two on the floor until 6 p.m. After 6 we still had a lot to do and ended up not having enough time to get in the bath R5 wanted. There was also another shower that was supposed to get done that we never got done."

Shower/bath records dated July to September 2020: R5 received a shower on 7/19 but not again until 8/17/20, and then not again until 8/24//20. R5 received a bath on 9/13/20, but not again until 9/21/20.

Review of R5's call light log from 9/1/20 (6:53 p.m.) to 9/29/20 (2:24 p.m.), indicated, R5 used the call light 166 times. Of the 166 instances, the wait time was over 20 minutes on 69 occasions or 41.5% of the time.

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.

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.

R7's care plan dated 7/29/20, included, R7 required assistance for, "Bathing with max to dependent assist, dressing with max assist, personal hygiene set-up with minimal assist, occasionally incontinent, and requires assistance with toilet use."

When interviewed on 9/24/20, at 1:31 p.m. a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 38	F 725		

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 night shift is customarily staffed with two NA's and 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 the individual needs of each resident. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 39	F 725		

morale among staff and residents is low because of this.

R7's call light response time logs dated from 9/22/20, at 3:51 a.m. to 9/28/20, 9:25 a.m. showed the call light was engaged 51 times over the seven day period. Of the 51 call light alerts initiated, 11 (or 21.5%) of these alerts took over 15 minutes to receive a response. Seven (or 14%) of these alerts took longer than 20 minutes to receive a response.

R4's admission Minimum Data Set (MDS) dated 6/29/20, included, moderate cognitive impairment with diagnoses including diabetes, dementia and arthritis. R4 required extensive assistance with toileting and limited assistance with personal hygiene. R4 was not on a toileting program and was occasionally incontinent of urine (less than 7 times during the assessment period).

R4's incontinence Care Area Assessment (CAA) dated 7/1/20 indicated, "Resident triggers for urinary incontinence r/t [related to] need for assistance with toilet use and bladder incontinence." "She is in PT [physical therapy] and OT [occupational therapy] at this time with the goal of returning to the community. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's significant change MDS dated 8/27/20, included severe cognitive impairment, was totally dependent upon staff for toileting and personal hygiene and was always incontinent of urine.

R4's incontinence CAA dated 8/28/20 included,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 40	F 725		

"Resident triggers for urinary incontinence r/t toilet use and bladder incontinence. Resident has declined in both mobility and cognitive function. She has recently enrolled in hospice for end of life cares. Resident uses incontinence products to aid in keeping skin dry. Plan to continue to with current toileting plan and complete peri cares q [every] AM [morning], HS [night], and with each incontinent episode."

R4's only Bowel and Bladder assessment in the medical record was dated 6/24/20, and indicated R4 was continent of bowel and bladder.

R4's care plan dated 6/26/20, included, "Alteration with elimination." Staff were directed to, "Assist of 1 with toileting." The care plan had not been updated since 6/26/20, even though the 8/27/20, MDS noted a decline in urinary incontinence to totally incontinent and an increase in assistance needs for toileting and personal hygiene.

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.

During continuous observation on 9/25/20, starting at 10:34 a.m. 2 staff members asked R4 if she would like to lay down. R4 verbally declined. No encouragement or re-approach was provided. No additional attempts to provide incontinence cares occurred. At 11:46 a.m. licensed practical nurse (LPN)-D brought R4 to her room to check blood sugar and administer insulin. LPN-D then brought R4 to the dining room. Incontinence cares were not provided. At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 41 1:58 p.m. NA-F and NA-B assisted R4 into bed and changed R4's visibly wet brief. 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 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 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. R4's call light log from 9/1/20 - 9/29/20 revealed R4 used the call light 20 times. Of the 20 instances the wait time was over 10 minutes on five occasions, over 40 minutes on one occasion, and over 60 minutes one occasion.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 42	F 725		

R1's quarterly Minimum Data Set (MDS) dated 8/20/20, included, severe cognitive impairment with diagnoses including TBI (traumatic brain injury) and dementia. R1 required extensive assistance with most activities of daily living (ADL's) and did not ambulate. R1 had 2 or more falls with injury since the prior assessment. R1 had a discharge MDS dated 9/16/20.

R1's care plan dated 9/2/20, included, "Fall risk AEB [as evidenced by] multiple falls since admission related to lack of safety awareness secondary to TBI and Dementia with behavioral disturbances." The goal for R1 was listed as, "Resident will be safe and free from serious injury should incident occur." Staff were directed to, "Provide one on one care, such as taking outside and wheeling her down the hall."

The facility provided a running list of R1's falls from 7/21/20 thorough 9/24/20, which indicated R1 had fallen in the facility 17 times in that time frame. 7/14/20, 7/31/20, 8/1/20, 8/5/20, 8/6/20, 8/11/20, 8/12/20, 8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20, 8/21/20, 8/29/20, 9/3/20, 9/14/20 and 9/15/20.

Hospital discharge summary dated 9/16/20, indicated R1 was transferred to the hospital on 9/15/20 after sustaining a fall related to increased agitation. Summary details R1 incurred a fractured skull and finger.

R1's progress notes from 9/16/20 to 9/21/20, revealed:
-9/16/20, at 4:36 p.m. R1 returned to the facility from the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 43	F 725		

R1's progress note dated 9/16/20, at 5:35 p.m. included R1 had attempted to crawl out of bed several times after returning from the hospital. Facility transferred R1 to her wheelchair, R1 then started to yell out and reported of pain in neck and back. R1 reported to facility of pain in her neck and back. R1 started to stand up from her wheelchair. Facility initiated a 2 to 1 staff to R1 ratio as the facility determined R1 was not safe. R1's physician was contacted and consulted and confirmed for the R1 to be sent back to the hospital. R1's guardian was informed of the transfer situation.

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.

R1's progress noted dated 9/16/20, at 6:28 p.m. included, R1 was noted to have continued marked behaviors: swore at staff, attempted to put herself onto the floor, yelling and hollering louder than her usual, R1 was extremely agitated and 1:1, 2:2, 3:3 were attempted and R1 remained aggressive towards staff. Facility called 911 to send R1 to emergency department (ED) for further evaluation per physician's orders.

When interviewed on 9/24/20, at 1:00 p.m. NA-B stated there were times when R1 required one on one attention, but they only had one or two staff to cover a unit of 30 residents, so this was not possible.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated they did not have enough help to watch R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 44 all the time and she fell a lot. When interviewed on 9/24/20, at 2:56 p.m. the emergency room social worker stated the facility would not take R1 back to the facility because they did not have enough help to watch her well enough. When interviewed on 9/24/20, at 3:22 p.m. NA-D stated R1 required a significant amount of staff time to prevent her from falling and they just did not have the time to stay with her all the time. NA-D stated she worked the day shift and often when arriving for her shift would find R1, "sopping wet," in her incontinent brief. When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated there was not enough staffing to supervise R1 and keep her safe as she required individual attention. When interviewed on 9/28/20, at 10:10 a.m. the DON stated due to limited staffing R1's needs could not be met at the facility, therefore R1 could not be readmitted after her last admission to the hospital. R3's admission minimum data set (MDS), dated 8/15/20, revealed R3 had moderate cognitive impairment. R3 required supervision and one staff physical assistance for eating. R1's diagnosis included a stroke. R3 had the following swallowing concerns: loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, and coughing during meals or when	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 45 swallowing medications. R3's care plan, last updated 9/24/20, directed staff, "The resident needs a calm, quiet meal time with adequate eating time. The resident requires all meals in the dining room r/t [related to] close supervision-not to receive meals until supervision is provided." When interviewed on 9/24/20, at 12:56 p.m. NA-A stated she worked day shift and considered it, "understaffed." NA-A reported residents waited to be provided morning cares prior to breakfast, especially if they required two staff and assistance with mechanical lift. NA-A stated, R3 required individual assistance for cueing him to not eat too quickly or take too big of a bite and to get enough fluid. NA-A noted R3 often had to wait over 40 minutes to eat until they had enough staff in the dining room to help him. When interviewed on 9/24/20, at 3:22 p.m. NA-D stated, R3 required staff to closely monitor to make sure he ate the amount he should. Often no staff were available to help, he would sit and look around the room, waiting for his plate of food. When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated, there were several residents that required assistance in the dining room and it was difficult to figure out how to feed R3. R3 required help the entire time due to choking precautions and required assistance the entire meal time. During observation on 9/25/20, at 12:21 p.m. R3 wheeled self into the dining room. R3 rolled his wheel chair back and forth at the table, looking around until his meal was brought to him at 12:41 p.m.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 46	F 725		

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated there is never enough staff in the dining room to feed everyone. "On a good day, we are lucky to have 2 aides to assist all the residents."

R8's admission MDS, dated 8/10/20, included, R8 was cognitively intact with a diagnosis of Parkinson's disease. R8 required physical assistance of 2 staff for transfers and supervision and one person physical assistance for toileting.

R8's care plan, last revised 8/24/20, directed staff, "Alteration in elimination r/t [related to] Parkinson's" and, "Assist of 1 with toileting as needed for hygiene."

When interviewed on 9/24/20, at 12:23 p.m. 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.

When interviewed on 9/28/20, at 10:37 a.m. R8 stated there was not enough staff to help her when she needed it. R8 stated she has problems with stiffness and decreased ability to do things on her own when her Parkinson's medication was late. R8 stated staff tell her they have a half hour

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 47	F 725		

on each side of the time her medication is due, but it is often over that. R8 stated staff tell her they do not have enough staff to get it to her on time. R8 stated she does not get enough help to the bathroom, she often has to wait 20-40 minutes to get on or off the toilet. This causes her back to hurt and she gets even more still and unable to care for herself even more.

R8's medication administration record (MAR), dated August 2020, included an order for Carbidopa-Levodopa (a medication for treating Parkinson's disease symptoms such as muscle stiffness, tremors, spasms, and poor muscle control) five times daily; 5:55 a.m., 10:00 a.m., 4:00 p.m., 7:30 p.m. and 11:30 p.m. R8 was noted as being administered the medications at each opportunity, but the time administered was not noted.

When interviewed on 9/28/20, at 10:58 a.m. LPN-D stated R8 wanted her medications on time. LPN-D stated R8 reported concerns with getting her medications on time in the evening.

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.

R13's care plan, dated 7/3/20, incontinence and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 48	F 725		

risk for skin breakdown and required staff assistance. The care plan indicated to keep the call light in reach and answer promptly.

When interviewed on 9/24/20, at 1:31 p.m. NA-C stated R13 was totally dependent on staff for cares. Sometimes R13 had to stay in bed for breakfast as they didn't have enough staff to get her up before breakfast. R13 would prefer to get up, but is agreeable when they need her to be. Often R13 would be, "saturated" by the time they were able to attend to her after breakfast.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated when coming on for the afternoon shift they would find R13 soaked in urine. NA-D was often the only staff on afternoons who was competent to use the mechanical lift needed to get R13 up, and due to this, often R13 had to stay in bed at supper time. This would upset R13, but they just didn't have enough help to always get her up.

When interviewed on 9/28/20, at 11:05 a.m. R13 stated she is incontinent of urine due to her 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, between 50 and 60 minutes on 5 occurrences and over 60 minutes on four occurrences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 49	F 725		

R12's quarterly MDS dated 8/14/20, included, R12 had moderate cognitive impairment. R12 was on hospice services and required oxygen care. R12's diagnoses included coronary artery disease, asthma/chronic obstructive pulmonary disease or chronic lung disease and respiratory failure.

R12's medication and treatment administration report (MAR/TAR), dated August 2020, directed staff, "Connect 02 1.5 L [liters]/min [minute] at bedtime." and "Oxygen at 1.5L/min per nasal cannula while at rest and at night. This was not marked as completed on the night of 9/4/20 and 9/17/20. The MAR/TAR directed "Ensure resident has bipap on every overnight, every night shift for cpap placement. Please ensure Cpap is in place every hour overnight." This was not marked as completed on 9/4/20 and 9/17/20. and "Bipap-Nurse must put on use daily when sleeping and at night." This was not marked as completed the night of 9/4/20 and 9/17/20.

On 9/24/20, at 3:45 p.m. LPN-B stated, R12's and family had concerns about staffing. LPN-B R12 was, "slower," and "needier," than other residents.

On 9/25/20 at 10:39 a.m. a family member of R12, (FM)-A stated she monitored R12's care through video. R12 wore a bipap mask at night and oxygen nasal cannula during the day to assist with respiratory and breathing issues. FM-A would notice times R12's bipap or oxygen was not applied, or not applied properly for significant amounts of time, noting recent example between 3:20 a.m. to 3:50 a.m.; 5:00 a.m. to 7:10 a.m., and 10:10 p.m. to 1:17 a.m. on 9/24/20. FM-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 50	F 725		

reported, during these instances, she would call the facility to alert staff, without response. During the interview, R12 noted she did not feel well when she was not getting the oxygen she needed, like she was in a "daze". FM-A reported R12 was deteriorating both cognitively and physically and was more confused when not on the oxygen. FM-A stated, on 9/18/20 to 9/19/20 she noted no camera activity, indicating no movement detected, in R12's room between 11:34 p.m. and 4:09 p.m. FM-A noted R12 required frequent monitoring to ensure her bipap was on properly. FM-A reported R12 had told her she felt like a burden to staff. FM-A reported she had informed the director of nursing of her concerns and there was no resolution or improvement.

R12's call light log, dated 9/1/20 to 9/29/20, included, R12 activated the call light 66 times. Eleven of those were answered in 10 to 20 minutes. Six were answered between 20 to 30 minutes. Six were answered between 30 to 40 minutes. One was answered between 40 and 50 minutes. Six were answered in over 60 minutes

When interviewed on 9/24/20, at 12:23 p.m. LPN-A stated there were not enough staff to care for residents. LPN-A explained there were sometimes only one aide on west side of the care center. Residents were not getting the timely care they needed with timely toileting, bathing and hygiene. The workload was stressful and contributing to staff burnout and turnover. LPN-A stated, she had discussed concerns with DON and administrator and there had been no resolution. LPN-A reported she helped the nursing assistants with cares when she was able but was busy with completing treatments and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 51	F 725		

medication pass for residents. LPN-A reported there was an overall concern with resident not getting the timely assistance with bathing and hygiene.

When interviewed on 9/24/20, at 1:31 p.m. NA-C reported she was pulled away from her nursing assistant duties to help with electronic medical appointments and wound rounds. There was not sufficient nursing staff to provide oral care and peri-cares for residents. The nurses were too busy with their own duties to assist. Most of the time baths and showers were missed and residents were not assisted with morning and evening cares when they preferred. Staff would chart a resident refused a bath, when the resident had not been offered, or chart a resident was bathed, when they were not bathed. This had been reported to both the DON and administrator with no changes.

When interviewed on 9/24/20, at 3:22 p.m. NA-D stated she worked the night shift and there were times when she would be the only nurse aid in the building. Resident call lights were on for extended periods of time- sometimes over an hour. They just could not get to them timely. At meal times residents complain of cold food. "Short staffing is a daily occurrence." This had been reported to the administrator but was told there was nothing they could do about it.

When interviewed on 9/24/20, at 3:45 p.m. LPN-B stated there was one or two aides for 30 residents. Nurses were expected to provide personal cares for 5 residents each shift in addition to their regular duties. Sometimes, they were not able to make sure resident treatments were completed. When staff come from a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 52	F 725		

staffing agency, they are reluctant to return as they do not have enough time to complete all of their work. LPN-B had reported this concern to management and was told they had enough staff.

When interviewed on 9/25/20, at 11:12 p.m. HSK-A stated nursing assistance seem to be, "burned out," because they do not have enough time to meet resident needs.

When interviewed on 9/28/20, at 3:36 p.m. the administrator, assistant administrator, DON and RN-A were interviewed together. There was no facility assessment to determine the specific staffing needs to meet resident care planned needs. Typically, there should be 1 nursing assistant per 10 residents. DON stated there were residents who complained about call light wait times, particularly at night time. RN-A stated, "The staff have made it seem so drastic" but noticed "a lot of standing around." The administrator noted she was working on team dynamics and culture change in response to staffing concerns. The administrator reported she was committed to improving the staffing situation and chipping in within her abilities. DON reported she felt there was an adequate number of staff but felt the communication was poor. DON reported there was a situation where there was too many staff and less work got done. RN-A reported there was fewer staff because the census was down.

The facility staffing policy, dated 10/17, directed staff, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care ad services for all residents in accordance with resident care plans and assessment." and "Staffing numbers and the skill

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 53 requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care."	F 725		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prepare food in accordance with residents needs for 2 of 3 residents (R5 and R10) reviewed who required modified texture diets. Findings include: 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. 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 consistency, small bites thorough mastication (chewing), swallow bites before taking another bite/sip, slow pacing, single sips, alternate between liquids/solids. The report indicated further analysis would be required to determine if	F 805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 54	F 805		

R10 would be appropriate 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.

R10's care plan dated 4/1/20, included, risk for nutritional alteration related to coughing during meals; had diet restrictions which included NDD2 [National Dysphagia Diet, level 2- meats are to be ground or are minced no larger than 1/4 inch pieces, they are moist, with some cohesion] diet and could have requested puree. Staff were directed to monitor, document, and report to the physician as needed for signs and symptoms of swallowing problems.

R10's undated nursing assistant Care Guide included mechanical soft diet with pureed meat.

R10's Nutrition Evaluation dated 4/16/20, identified a mechanical soft diet with pureed meat. Speech therapy recommended to, "have all meats ground, unless resident request pureed for preference."

R10's Oral/Dental Evaluation dated 7/14/20, indicated R10 had full upper and lower dentures.

During observation on 9/25/20, at 12:42 p.m. R10 was observed to be coughing while eating. At 12:47 p.m. it was noted R10 was eating a regular hamburger patty on a bun. R10 stated it was hard to eat because she did not have her dentures in. She had requested the regular patty as the staff had grilled out the burgers and she desired one. R10 continued to cough while eating, no one checked to see if she was alright,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 55	F 805		

nor did anyone bring her dentures.

R10's lunch tray ticket included, "Mechanical soft texture and to provide ground grilled hamburger, potato salad, no raw veggies, beans, shredded lettuce."

When interviewed on 9/25/20, at 1:06 p.m. dietary aide (DA)-A stated residents who require a mechanical soft diet should have been provided with ground meat. R10 coughing is something she normally does while eating.

When interviewed on 9/25/20, at 1:12 p.m. cook (CK)-A stated, a mechanical soft diet should have ground meat, no bread or hard vegetables. The cook is the person responsible to ensure the correct diet is served.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated R10 does cough at meals, she was unaware R10 did not have dentures in. NA-F stated if someone is coughing like that, they should go get a nurse to assess if no nurse was in the dining room.

When interviewed on 9/25/20, at 1:34 p.m. R10 stated she normally gets a ground burger, but today got a regular whole burger as they were grilling them. R10 stated she normally wore her dentures, but forgot them today. Staff sometimes have to remind her to put them in or help her with them. At 1:39 p.m. R10 was coughing and NA-H asked her if she was ok.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated resident's diets could be upgraded if they wished for an upgrade, but would have to sign a risk versus benefits statement. R10 did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 56	F 805		

a risk versus benefits statement signed nor was she given the risks of choking when provided with a regular hamburger today.

When interviewed on 9/25/20, at 3:08 p.m. Cook-A stated they have a file of each resident who had signed a risk versus benefits statement for a diet upgrade, then if they ask for an upgrade they can provide it. R10 did not have one of these. R10 should have been provided the ground meat diet as ordered and not a regular hamburger.

R10's Diet Requisition Form provided by Cook-A and dated 3/31/20, had been completed by speech therapy and indicated R10 was to have a Mechanical Soft/Ground Meat NDD2 diet consistency and patient could downgrade to pureed food if desired.

When interviewed on 9/28/20, at 10:21 p.m. the registered dietician (RD) stated if a resident were coughing during a meal it should be reported to the DON, food service director and speech therapy. This had not been done for R10. The facility should not provide an upgraded texture diet without risks being explained to the resident and a form signed.

When interviewed on 9/28/20, at 2:37 p.m. the DON and RN-A stated it is important to provide the correct diet texture for residents with swallowing problems. A nurse should be notified if a resident is coughing.

R5's quarterly MDS dated 9/4/20, indicated no cognitive impairment with diagnoses including, stroke, epilepsy. The MDS noted R5 had

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	245090	A. BUILDING _____ B. WING _____	C 09/28/2020

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PLEASANT MANOR LLC	**27 BRAND AVENUE FARIBAULT, MN 55021**

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F 805	Continued From page 57	F 805		

coughing and choking during meals or when swallowing medications during the assessment period. The MDS further indicated supervision, oversite, set up when eating and mechanically altered textures.

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.

R5's Care Assessment Area Worksheet (CAA) dated 1/20/20, indicated R5 required a mechanically altered diet. There was no analysis completed, but was noted to proceed to care planning.

R5's care plan dated 3/20/20, indicated R5 was at risk for nutritional alteration related to chronic pain front thorax and diet restriction for NDD3 diet. Staff were directed to monitor, document and report to physician for signs or symptoms of dysphagia when eating.

R5's Progress note dated, 1/25/19, indicated her diet was changed to NDD3 by Speech therapy.

R5's Nutritional Evaluation dated 9/4/20, identified a diet order for NDD3, Dysphagia Advanced diet level 3.

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F 805	Continued From page 58	F 805		

R5's Care guide for staff indicated a regular diet and independent in dining room which is different from MDS 9/4/20, CAA 1/20/20, Medical Record, physician order and care plan.

R5's lunch tray ticket included a diet order for Dysphagia Advanced diet (NDD3). The tray ticket further directed to provide chopped, grilled hamburger on bun, potato salad, no raw vegetables, backed beans, no bacon, shredded lettuce, soft ice cream and milk.

During an observation on 9/25/20, at 12:50 p.m. R5 sat alone at a table and was noted to cough while she ate her meal. R5's plate contained a whole hamburger with a wedge of lettuce that covered the burger on a bun and potato chips. There were various staff throughout the dining area including nursing and dietary, but no one stopped to see why R5 was coughing. At 12:52 p.m. R5 was observed to be shaking and asked for someone get a nurse because she was having a seizure. Staff came and brought R5 out of the dining room.

When interviewed on 9/25/20, at 1:06 p.m. DA-A stated R5 should have received ground meat, beans, potato salad, soft cooked vegetables. R5 should not have had a bun, the burger should have been ground and should not have received potato chips or whole leaf lettuce.

When interviewed on 9/25/20, at 1:10 p.m. R5 stated she has occasional seizure that are like, "spells," and has no diet restrictions.

When interviewed on 9/25/20, at 1:12 p.m. Cook-A stated the facility provided NDD3, NDD2 and pureed textures. A mechanical diet should

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F 805	Continued From page 59	F 805		

have ground meat, no bread or hard vegetables. For the noon meal provided on 9/25/20, a mechanical texture should have included, no bun, ground hamburger, potato salad and beans. It was the cook's responsibility to make sure a resident is getting the appropriate texture.

When interviewed on 9/25/20, at 1:21 p.m. NA-F stated staff should check on residents who are coughing and should get a nurse. R5 should have received the correct diet and did not know who gave her the wrong diet.

When interviewed on 9/25/20, at 1:40 p.m. Dietary Aide-A reported both dietary and nursing aides deliver meal trays.

When interviewed on 9/25/20, at 3:06 p.m. RN-B stated a resident is ok to be provided an upgraded texture if a risk and benefit form had been signed. The resident should be given the order from the physician if there is no signed risk and benefit form. R5 did not have a signed form.

On 9/25/20 at 3:08 p.m. Cook-A- stated R5 should have received the ordered diet, but did not, the Cook is responsible for providing the correct diet.

The facility Refusal of Care/Interventions, Risk and Benefits policy dated 9/11, identified a resident would be informed of the risk and benefits of necessary care and given the opportunity regarding their decision in the plan of care. The resident would be approached 2-3 times and if resident continued to refuse, documentation should be made on the Refusal of Care Interventions Risk and Benefits and reviewed quarterly.

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F 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 soft, well-cooked vegetables. Vegetables should be less than 1/2 inch and should be easily mashed with a fork.	F 805		