

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

Kamala Fiske Downing

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: kamala.fiske-downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 13, 2020

Administrator Pleasant Manor LLC 27 Brand Avenue Faribault, MN 55021

RE: CCN: 245090

Cycle Start Date: September 28, 2020

Dear Administrator:

On September 28, 2020, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

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

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

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

Kamala Fish Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 11/02/2020 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | L. IDENTIFICATION NUMBER. | | FIPLE CONSTRUCTION NG | ` ' | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | ı | C / 28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | 1 30. | 20,2020 | |
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| F 000 | survey was comple complaint investiga not to be in compliant Requirements for L. The following composition of the following composition of the following composition of the facility's plan of as your allegation of Department's acceptant of the following of the facility | 0 and 9/28/20, an abbreviated ted at your facility to conduct a tion. Your facility was found ance with 42 CFR Part 483, ong Term Care Facilities. Plaints were found to be 977 and F725 77, F686 and F725 Plaints were found to be 15090055C and H5090058C. If correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will | F O | 00 | | | |
| | on-site revisit of you validate that substa | | F 5 | 50 | | 11/2/20 | |
| LADODATOR | self-determination, access to persons outside the facility, this section. | nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in | NATURE | TITLE | | (X6) DATE | |

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

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ` ′ | TIPLE CONSTRUCTION | COM | (X3) DATE SURVEY COMPLETED | |
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| F 550 | §483.10(a)(1) A fawith respect and or resident in a mann promotes mainten her quality of life, individuality. The findividuality. The findividuality. The findividuality of conditions the resident of conditions are stablish and practices regarding provision of services residents regardle. §483.10(b) Exercitable Services as a resider or resident of the life services and to be serviced from the facility. §483.10(b)(2) The free of interference, coerd from the facility. §483.10(b)(2) The free of interference from the facility. Services of his or subpart. This REQUIREMED by: Based on observative, the facility review, the facility | cility must treat each resident lignity and care for each her and in an environment that ance or enhancement of his or recognizing each resident's acility must protect and of the resident. I facility must provide equal care regardless of diagnosis, on, or payment source. A facility dimaintain identical policies and gransfer, discharge, and the es under the State plan for all se of Rights. The right to exercise his or her at of the facility and as a citizen United States. In facility must ensure that the case his or her rights without con, discrimination, or reprisal the resident has the right to be decorrion, discrimination, and accility in exercising his or her apported by the facility in the her rights as required under this enter in a otted dignity for 1 of 1 resident | F 5 | F550=D. Based on observative interview, and document refacility failed to provide cathat promoted dignity for 1 (R7) reviewed for dignity to | review, the re in a manner I of 1 resident | | |

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| F 550 | Findings include: R7's admission M 7/28/20, included with a diagnosis o incontinent and re person to transfer R7's ADL (activitie Rehab Care Assed dated 9/25/20, included in mobility of bowel and blade toileting upon required assistant dependent assist, personal hygiene occasionally incom with toilet use." When Interviewed was lying in bed. If facility is very bad there seems to be facility. Call lights hour. I push the call bathroom and no wet myself. I feel chair and embarra cleaned up and ch brow was furled an R7 stated this hap When interviewed nursing assistant of wait for assistance wait for assistance | inimum Date Set (MDS) dated moderate cognitive impairment f a stroke. R7 was occasionally quired assistance by one staff on and off of the toilet. s of daily living)/Functional ssment Area Worksheet (CAA) luded, R7 has had a recent, was occasionally incontinent der, and needed assistance for | F 5 | The residents of Pleasant I right to receive care in a digit is the responsibility of all facility to ensure the reside care promotes their dignity rights. The associated policies rel providing care in a dignified reviewed and remain approximate approximate approximate and remains approximate appear to be appropriate and additionally will implement Advocate Program that will promoting timely response concerns. Education of executing a to care will be completed for and IDT will be educated on Advocate Program. Administrator/DON or designer form audits weekly x 4 x x 3 months, and quarterly the ensure compliance. Audit reviewed monthly at QAPI further recommendations. Date of completion: 11/2/20 | gnified manner. staff of the ents' plan of and resident ated to d manner were opriate. ng was ropriate for All resident's eviewed, bileting plans t this time. IDT a Resident assist in to resident bileting plan of all nursing staff n Resident gnee will weeks, monthly thereafter to results will be meetings for | |

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| F 550 | Most residents waitime to receive an has assisted R7 af secondary to waiting time for the call light that there have been beginning of the shoiled and need as night shift is custor one licensed pract nurse (RN) for the facility. When interviewed LPN-D state there individual needs of among staff and re R7 being incontine to her timely is a described of the call light responsible to her timely is a described of the call light responsible to her timely is a described of the call light responsible to receive a responsi | it for an extended period of answer to their call light. NA-D feer R7 was incontinenting for a prolonged period of the tobe answered. NA-D stated en, "too many times," at the nift when several residents are esistance. NA-D stated the marily staffed with two NA's and ical nurse (LPN) or registered 42 current residents in the on 9/25/20, at 2:55 p.m. is insufficient staff to meet the esidents is low because of this. In the due to not being able to get ignity issue. In the sendand of the serious dated from m. to 9/28/20, 9:25 a.m. the was engaged 51 times over od. Of the 51 call light alerts 5%) of these alerts took over vive a response. Seven (or the stook longer than 20 minutes assessment in place to assist in geneds at this time. The end current staffing rations are med to the administrator stated that the administrator stated that the administrator stated that | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED C | | |
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| | CFR(s): 483.15(d)(§483.15(d) Notice of §483.15(d)(1) Notice of survival facility transitive resident goes of nursing facility must the resident or residency facility must resident or residency facility; (ii) The duration of the any, during which the return and resume facility; (iii) The reserve been plan, under § 447.4 (iiii) The nursing face bed-hold periods, where we have a survival facility in the information of this section. §483.15(d)(2) Bed-the time of transfer hospitalization or the facility must provide resident representates a specifies the duration described in paragraph to the survival facility failed to issue the survival facility failed to issue the survival facility failed to issue facility failed to issue the survival facilit | of bed-hold policy and returnate before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the trovide written information to dent representative that the state bed-hold policy, if he resident is permitted to residence in the nursing a payment policy in the state of of this chapter, if any; illity's policies regarding which must be consistent with this section, permitting a land in specified in paragraph (e)(1) thold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the lative written notice which can of the bed-hold policy raph (d)(1) of this section. Note that the section is not met as evidenced and review and interview, the lea written bed-hold notice thospital for 1 of 3 residents | F 62 | F625=D. Based on docume interview, the facility failed to written bed-hold notice upon the hospital for 1 of 3 reside reviewed for hospitalizations Prior to transfer, it is the reside the Pleasant Manor staff to design to the staff to the | o issue a i transfer to nts (R1) s. ponsibility of | 11/2/20 |

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| F 625 | Continued From pa | ge 5 | F 62 | 5 | | |
| | 5/20/20, indicated F 5/14/20 with a disch anticipated MDS da | | | bed-hold to the resident being train The bed-hold policy has been reviand remains appropriate. All nurses and IDT members will leducated on the bed-hold policy a | iewed be and the | |
| | included, R1 was tra full report was giver | dated 9/16/20, at 6:24 p.m. ansferred to the hospital and a n to the police and transport ped hold notice was not found ord. | | steps to carry out offering a bed-h during a transfer to the hospital. Administrator or designee will per audits weekly x 4 weeks, monthly months, and quarterly thereafter to compliance. Audit results will be re- | form x 3 o ensure | |
| | guardian reported s | on 9/24/20, at 3:07 p.m. R1's she had not been provided a n and was unaware of the ne bed for R1. | | compliance. Audit results will be reviewed monthly at QAPI meetings for further recommendations. Completed 11/2/2020 | | |
| | interim director of n | on 9/28/20, at 2:09 p.m. the ursing (DON) verified a written s not completed for R1. | | | | |
| | Emergency revised bullet number 4: "The responsible for: b. or her representative | Transfer or Discharge, on 08/2018, indicated under he business office is Informing the resident, or his re (sponsor) of our facility's I rights, bed-holding policies, | | | | |
| | ADL Care Provided CFR(s): 483.24(a)(2 | for Dependent Residents 2) | F 67 | 7 | | 11/2/20 |
| | out activities of daily services to maintain personal and oral h | ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced | | | | |
| | Based on observat | ion, interview, and document ailed to provide incontinence | | F677=D. Based on observation, interview, and document review, t | he | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | | 30/2020 | |
| NAME OF | PROVIDER OR SUPPLIER | 240000 | | STREET ADDRESS, CITY, STATE, ZIP CO | | 28/2020 | |
| | NT MANOR LLC | | | 27 BRAND AVENUE FARIBAULT, MN 55021 | ,DL | | |
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| F 677 | care timely, and fai status after a signif residents (R3) review Findings include: R4's admission Min 6/29/20, included, with diagnoses included arthritis. R4 requires toileting and limited hygiene. R4 was reast was occasionally in times during the assistance with toil incontinence." "She and OT [occupation the goal of returning uses incontinence dry. Plan to continuand complete perior HS [night], and with R4's significant chaincluded severe condependent upon standing the significant chaincluded in both me sha recently elife cares. Resident regions are significant chaincluded severe condependent upon standing the significant chaincludes are significant chaincludes. | ciled to reassess continence icant change for 1 of 3 ewed for incontinence. Inimum Data Set (MDS) dated moderate cognitive impairment uding diabetes, dementia and ed extensive assistance with diassistance with personal not on a toileting program and incontinent of urine (less than 7 esessment period). Care Area Assessment (CAA) ited, "Resident triggers for e r/t [related to] need for | F 67 | facility failed to provide incontimely, and failed to reassess status after a significant char residents (R4) reviewed for in Pleasant Manor staff have the responsibility to provide care who are unable to carry out a daily living to promote their hincluding assessment during and providing care daily. The associated policies relat plans have been reviewed an appropriate. R4's toileting plans have been reviewed and updated. All retoileting plans have been reviewed as an IDT and toil appear to be appropriate at the Staff will be educated on executive to the signed will perform weekly x 4 weeks, monthly x and quarterly thereafter to ercompliance. Audit results will monthly at QAPI meetings for recommendations. Completed 11/2/2020 | s continence age for 1 of 3 ancontinence. The to residents activities of ealth, their stay and remain an was esident's iewed, eting plans his time. Ecuting re. In audits 3 months, asure | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | | S ⁻ | TREET ADDRESS, CITY, STATE, ZIP CODE 7 BRAND AVENUE ARIBAULT, MN 55021 | 1 09/2 | 20/2020 |
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| F 677 | Continued From pa | ge 7 | F 6 | 77 | | | |
| | | n and complete peri cares q g], HS [night], and with each e." | | | | | |
| | medical record was | d Bladder assessment in the dated 6/24/20, and indicated f bowel and bladder. | | | | | |
| | "Alteration with elim to, "Assist of 1 with not been updated s 8/27/20, MDS noted incontinence to total | ed 6/26/20, included, nination." Staff were directed toileting." The care plan had ince 6/26/20, even though the d a decline in urinary ally incontinent and an increase is for toileting and personal | | | | | |
| | "Assist of 2 w/ Hoye ambulate." No info | ant Care Sheet included, er [mechanical lift]; does not rmation was included to direct on how to attend to R4's | | | | | |
| | starting at 10:34 a.r if she would like to declined. No encou provided. No addition incontinence cares licensed practical inher room to check insulin. LPN-D then room. Incontinence 1:58 p.m. NA-F and and changed R4's variety and changed R4's vari | • | | | | | |
| | and NA-B stated th | on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
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| | | 245090 | B. WING _ | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 677 | since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge without being assis When interviewed director of nursing should be assisted hours. The DON structure and Bladder assess 6/24/20, noting it in bladder. RN-A revisidentified R4 had not Bladder assessment significant decline in June of 2020. RN-an updated assess change MDS compexplained they were R4 was on their wo should have been of changed at least extended. The facility policy To 11/2019) identified, incontinence production care plan is to be more considered. | ist R4 to lie down or toilet of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. on 9/28/20, at 3:05 p.m. the (DON) stated, she thought R4 with incontinent cares every 2 tated she did not know R4's egistered nurse (RN)-A who wed R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and ot had an updated Bowel and an condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4 shecked for incontinence and | F 67 | 7 | | |
| | | Prevent/Heal Pressure Ulcer 1)(i)(ii) | F 68 | 6 | | 11/2/20 |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION (X3 | (X3) DATE SURVEY COMPLETED C | |
|--------------------------|--|---|---------------------|--|------------------------------|--|
| | | 245090 | B. WING | | 09/28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | |
| F 686 | resident, the facility (i) A resident receive professional stands pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with professional stands promote healing, promote hea | regrity sure ulcers. brehensive assessment of a r must ensure that- res care, consistent with ards of practice, to prevent d does not develop pressure adividual's clinical condition they were unavoidable; and bressure ulcers receives ant and services, consistent tandards of practice, to revent infection and prevent eveloping. NT is not met as evidenced attion, interview, and document failed to provide repositioning sidents (R4) reviewed who eloping pressure ulcers. ange Minimum Data Set (MDS) anded severe cognitive diagnosis of dementia. R4 assist for bed mobility and the for transfer. R4 was at risk development, but did not have | F 686 | , | ents of 4's ed as in | |
| | incontinence. Residuent down r/t cognitive in | nd bowel and bladder dent is at risk for skin break mpairment, dx [diagnosis] of] and Type 2 DM [diabetes] | | plans of care have been reviewed, discussed at IDT, and repositioning pl of care remain appropriate. All nursing staff will be educated on th | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245090 | B. WING | | | C 09/28/2020 | |
| NAME OF I | PROVIDER OR SUPPLIER | | 1 | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 03/2 | 20/2020 |
| | | | | 2 | 7 BRAND AVENUE | | |
| PLEASA | NT MANOR LLC | | | F. | ARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 686 | and daily use of AS [blood thinner]. She bladder. Resident over skin tear on L otherwise intact. P place with toileting hours, pressure re wheelchair and ma cares q [every] AM weekly skin inspection by nurse order. Pressure redistributing inspection plant in R4's care plan furting in the staff]. Maxi lift (Hout inspection in comfolist) and in the staff]. Maxi lift (Hout inspection in comfolist) in the staff in t | SA [aspirin] and Coumadin e is incontinent of bowel and noted to have scabbed area LE [lower left extremity]. Skin reventative skin measures in and repositioning q [every] 2 distribution cushion to attress to bed, routine skin I [morning] and HS [night], and stions." ed 6/26/20 included, "Potential attegrity." Staff were directed to, rity daily. Weekly skin e. Treatment to open areas per distribution mattress to bed. Ition cushion to wheelchair, atterventions updated 9/1/20. The indicated, "Alteration in end of life" with interventions: ed mobility: A1-2 [assist of 1-2 yer) [mechanical lift] with direposition Q2H [every 2 by R4's care plan specified, ort," with an intervention dated 2hrs [every 2 hours] and PRN | F 6 | 886 | repositioning policy. DON or designee will perform audit weekly x 4 weeks, monthly x 3 mo and quarterly thereafter to ensure compliance. Audit results will be remonthly at QAPI meetings for furth recommendations. Completed 11/2/2020 | nths, viewed | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP O 27 BRAND AVENUE FARIBAULT, MN 55021 | | 72072020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 686 | starting at 10:25 a.i. herself in the whee effectively adjust he members asked R4 R4 verbally decline offered to recline R declined. No encouprovided. No additioccurred. At 11:46 (LPN)-D brought R4 sugar and administ repositioned. LPN-I room. At 1:55 p.m. NA-B assisted R4 i bed using 2 pillows stated, "Oh God, the pain was in her back." When interviewed and NA-B stated the morning cares at 7 not had time to assisted getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge the same position i repositioned. R4 shours. When interviewed adirector of nursing repositioned every. The facility policy R5/2013) identified, resident who is immediate resident who is immediate the same who is immediately policy R5/2013) identified, resident who is immediately adjusted to the same position of the | m. R4 was attempting to adjust Ichair, but was not able to erself. At 10:34 a.m. 2 staff 4 if she would like to lay down. d. The 2 staff members 4's wheelchair. R4 verbally tragement or re-approach was onal attempts to reposition a.m. licensed practical nurse 4 to her room to check blood er insulin. R4 was not D brought R4 to the dining nursing assistant (NA)-F and nto bed and positioned her in . As R4 was laid in bed she eat hurts." R4 specified that the exk. In 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or reposition of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and ad R4 had gone 6.5 hours in the chair without being hould be repositioned every 2 | F 68 | 6 | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | | E SURVEY PLETED |
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| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | every 1 hour (q1 ho Residents who are an every 2 hour (q2 schedule." Facility p Wound Manageme identified "A weekly completed by licens | in a chair should be on an ur) repositioning schedule. in bed should be on at least hour) repositioning policy Skin Assessment and int (revision date 7/2018) skin inspection will be seed staff." azards/Supervision/Devices 1)(2) | F 68 | | | 10/1/20 |
| | The facility must en §483.25(d)(1) The ras free of accident le §483.25(d)(2)Each supervision and assaccidents. This REQUIREMEN by: Based on observat review, the facility fassess 3 of 5 resid had fallen, and impliparevent further falls for R1 when she su and fractured her sl failed to ensure 2 or reviewed for chokin ordered modified te Findings include: R1's quarterly Minin 8/20/20, included, swith diagnoses includes | sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced ion, interview and document ailed to comprehensively ents (R1, R4, and R3) who ement interventions to . This resulted in actual harm stained 19 falls, broke a finger kull. In addition, the facility f 5 residents (R10 and R5) g risk were served the | | F689=G. Based on observation, interview, and document review, the facility failed to comprehensively as of 5 residents (R1, R4, and R3) whe fallen, and implement interventions prevent further falls. This resulted actual harm for R1 when she susta falls, broke a finger and fractured his skull. In addition, the facility failed ensure 2 of 5 residents (R10 and R reviewed for choking risk were servordered modified texture diet. Pleasant Manor ensures that the residents' environments remain saft as free of accident hazards as possible to the facility identifies each resident for accidents and develops a plant of | ssess 3 o had to in ined 19 ier to 85) ved the fe and sible, at risk | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | SURVEY PLETED |
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| | | | A. BOILD | | | | |
| | | 245090 | B. WING | | | 09/2 | 28/2020 |
| | PROVIDER OR SUPPLIER NT MANOR LLC | | | 27 | TREET ADDRESS, CITY, STATE, ZIP CODE 7 BRAND AVENUE ARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | assistance with mo (ADL's) and did not falls with injury sinchad a discharge MI R1's falls Care Area included, "Resident having impaired ba medication use. Refollowing hospitalization infection] and increasing infection and increasing the factor of the f | st activities of daily living ambulate. R4 had 2 or more the prior assessment. R1 DS dated 9/16/20. Assessment dated 5/22/20, a triggers for falls r/t [related to] lance and daily psychotropic esident has decreased mobility ation for a UTI [urinary tract ased behaviors. Resident was motor vehicle accident] last fered multiple major injuries nited to: skull fractures, TBI, rist fractures." "Resident is at alls r/t cognitive impairment, use of psychotropic, hypertensive, and edications. She is incontinent er. She does not have a to admission and has not had ission. Resident was moved the nurses station for safety, monitor for safety, keep call ollow therapy The CAA indicated falls d in the care plan. I Review Evaluation dated check list of risk factors for the 5/22/20 CAA. However, sis of fall risk factors or eventions that may mitigate or | Fé | 689 | addressing safety issues and imple procedures to prevent accidents ar incidents. The policy related to assessment of have been reviewed and remain appropriate. The policy related to modified textured diets has been reand remain appropriate. R4 and R3's incidents have been reviewed, assessed, and plan of caupdated. R1 has been discharged the facility. All resident's incidents been reviewed, assessed, and plan care updated appropriately. All resident textures plans of care have be reviewed and remain appropriate. Nurses were educated on post fall evaluation process and IDT was earnly sis and expectations regarding timely completion. Culinary staff we educated on proper service of mod textured diets Administrator/DON or designee will perform audits weekly x 4 weeks, rx 3 months, and quarterly thereafted ensure compliance. Audit results we reviewed monthly at QAPI meeting further recommendations. Completed 10/1/2020 | f falls reviewed are from have n of ident's en lucated nd g ere ified nonthly r to ill be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245090 | B. WING | | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | 2 | | 27 B | EET ADDRESS, CITY, STATE, ZIP CODE RAND AVENUE RIBAULT, MN 55021 | | 20/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD BE COMP | | (X5) COMPLETION DATE |
| F 689 | "Resident will be a should incident or use one assist for Place bed on low both sides of bed. unless providing or chair for comfort. in wheel chair. Protaking outside and R1's Action Summidentified R1 had 7/31/20, 8/12/20, 8/16/20, 8/21/20, 8/29/20, addition, R1's progress notes identified on the Adated 8/11/20, 8/19/14/20. Twelve of progress notes as mat next to the be 8/5/20, 8/6/20, 8/1 times, 8/29/20, 8/1 times, 8/29/2 | le goal for R1 was listed as, safe and free from serious injury cur." Staff were directed to, transfers with a standing lift. position. Have fall mats on Leave door open at all times cares. Use a tilt-in-space wheel To be visually supervised when ovide one on one care, such as divided wheeling her down the hall. In any dated 7/1/20 to 9/28/20, fallen 17 times on 7/14/20, 8/16/20, 8/16/20, 8/11/20, 8/16/20, 8/16/20, 8/19/20, 8/16/20, 8/16/20, 8/19/20, 10/20, 9/3/20, 9/14/20 and 9/15/20. In gress notes dated 7/29/20 and she had fallen, but these were expected a control of the falls were identified in the special of the falls were identified in the special of the falls were on 7/31/20, 6/20 - three times, 8/21/20-3 (30/20, and 9/3/20. 2 falls were wheel chair on 8/29/20 and more cliner on 7/29/20. There attended to determine the standard of the falls that occurred on 3/11/20, 8/12/20, 8/19/20 or siew and Analysis dated 7/20/20, found on the floor on 7/14/20. Included, "Staff was walking by and saw resident lying on the with lack of safety awareness | Fé | 689 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| F 689 | which contributes diagnosis of unsp consciousness; D disturbance." The listed: proper food (physical therapy/ lowest position and to be visually super provide tilt-in-sparecline resident we comfort. Staff prosuch as taking he down the hall. "Reside times heard yelling attention to staff a reassurance. Resident's self transtotend to her." The tothe care plan. R1's progress not [certified nursing a [10:00 a.m.] that rechair. Upon enter sitting on the footing resident back to self-in the care was not assent to her bed." Abra There was no assent interventions added to the sitting on the footing resident back to self-in the care was not assent the command found recommand found recommendations and found recommendations and found recommendations and found recommendations and found recommendations are sufficiently as a found for the found recommendation and found recommendations are sufficiently as a found for the found for the found found recommendation and found recommendations are sufficiently as a found for the found found recommendation and found for the found for | to resident's fall risks due to ecified TBI w/o loss of ementia with behavioral efollow-up/intervention section twear, evaluation by PT/OT occupational therapy), bed in d soft touch call light. Resident ervised when in wheelchair. See wheelchair with the ability to hen in chair to provide ore eviding 1:1 (one on one) care outside and wheeling her esident with behaviors and often g. Resident requires 1:1 and to redirect and provide sident is at high fall risk due to reness due to TBI and ent also experiences agitation and could be the reason of experiences interventions were added to edated 7/29/20, included, "CNA essistant] told writer at 1000 esident had slid forward in her ing room writer found resident est of her recliner and the forward. Three staff assisted eat [sic] of the chair." The dated 7/31/20, included, "At ard resident calling out from her esident on the floor laying next sions were noted to both knees. essment of this fall. Ed were, "All staff will make sure in door is not closed completely and the sident calling out grown and completely in the complete of the completely in the complete of the completely in the complete of the complete of the completely in the complete of the completely in the complete of the complete of the completely in the complete of the | | 689 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | IPLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED C | | |
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| | | 245090 | B. WING _ | | 09 | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 689 | dark." Keeping the room is dark was n R1's Incident Revie 8/5/20, identified R 7/31/20. The reporout of room." No further was documented. Of notifying the nurse anxiety, agitation, rechange in medication restlessness, and a R1's Incident Revie 8/5/20, identified R on 8/1/20. The form to get out of room." intervention as the 7/31/20. There was regarding this fall. R1's progress note "Resident found on out. Asked her what going to the floor." this. R1's progress note included, "Writer note included, "Writer note included, "Incomplete the resident of the roote included, "Aid calle included, "A | bathroom light on when the ot added to the care plan. we and Analysis report dated a was found on the floor on the identified R1 wanted to, "get urther assessment of this fall. However, a new interventions be practitioner of, "frequent estlessness and request a consto decrease anxiety, agitation," was requested. we and Analysis report dated a had been found on the floor midentified, "Resident wanting and This listed the same 8/5/20 report for the fall on son assessment completed and added 8/6/20, included, floor by bed on knees. yelling at she was doing and she said and there was no assessment of a dated 8/16/20, at 3:46 p.m. The political by TMA [trained and the physician was then eased anxiety and additional tion was ordered. R1 indicated and writer into room. Resident and writer into room. Resident and and torso was still in the | F 68 | 39 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION IG | | TE SURVEY MPLETED |
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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021 | | 120/2020 |
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| F 689 | bed. Resident was facility." R1's progress note included, "Aid calle sitting on floor with was wanting to leave R1's progress note included, "Resident bed. Resident had slid out of her bed. leave facility and came out of here." R1's progress note "Writer observed remat next to bed this at lowest position. happened and reside of here." R1's progress note 2:15 PM writer hea Writer found reside her W/C [wheel chaw Writer found 1" [incomposed of the continuous foot peda incontinence noted to writer what happ my head." Cool we | confused and wanted to leave dated 8/16/20, at 10:35 p.m. d nurse in to find resident arms on the bed. Resident | F 68 | 39 | | |
| | "Writer heard repeat room and found res | dated 8/30/20, included, ated yelling out from resident's sident on the floor next to her west position, call light within | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | ONSTRUCTION | ` ´COM | E SURVEY IPLETED |
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| | | 245090 | B. WING | | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | | 27 BF | ET ADDRESS, CITY, STATE, ZIP CODE RAND AVENUE BAULT, MN 55021 | <u> 09/</u> | 20/2020 |
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| F 689 | reach, fall mats in president not incontiin R1's progress note on right index finge. There was no incide determine when the R1's progress note physician had been index finger. R1's progress note sore right finger." R1's treatment recommonitor right index. However, it did not injury. R1's progress note "Writer heard reside when writer arrived floor next to her been up. Bed was in low place and call light. Even though R1 had there was no compedetermine the reason pattern in time determine why the working to prevent. R1's progress note "Monitor right index bed and part of finger strength in the progress note and part | dated 8/30/20, noted a bruise r and a scrape on her head. ent report or assessment to ese injuries occurred. dated 8/31/20, included, the updated on bruise to right dated 9/2/20, included, "Ice to ord identified staff were to finger related to a fall. identify which fall caused this dated 9/3/20, included, ent yelling from her room and resident was sitting on the dyelling, "Help me get back rest position with fall mats in in reach." d fallen from bed 13 times, rehensive assessment to on R1 was falling from bed, of day or situation, or to current interventions were not further falls. dated 9/10/20, included, finger related to a fall." "Nail | F 6 | 89 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION IG | | TE SURVEY MPLETED C |
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| | | 245090 | B. WING _ | | 09 | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 689 | "Monitor right index "Patients finger cornail bed no redness remains intact at the R1's Incident Revieg 9/15/20, identified F wheelchair on 9/15, cause of R1's fall fr. The form identified emergency room for wound. R1's hospital Admisdated 9/15/20, included a good for in bedroom an herself on floor at nagitated/verbally upupstairs." The result an acute nondisplay posterial parietal behospital discharges sustained a closed her right hand 2nd before returning to fracture was in a sthad happened in than injury to R1's right progress notes on a stated R1 had falled wheel chair, she was remainded to the result of the right had falled wheel chair, she was remainded to the result of the result of the right had falled wheel chair, she was remainded to the result of the | a finger related to a fall." Intinues to be black around the sor warmth noted to site. Nail is time." Ew and Analysis report dated R1 had fallen from her /20. No assessment of the rom the chair was completed. R1 was sent to the for evaluation due to a head revaluation due to a head revaluation due to a head resident and then seemed to throw hursing station. She has been reset at times. Wanting to go relate times. Wanting to go relate times. Wanting to go relate times and a fracture of the left resummary identified R1 had skull fracture and a fracture of finger which would be splinted the nursing home. The finger report age of healing, identifying it repast. The facility identified the index finger in the the 8/30/20. However, this was physician or x-rayed until | F 68 | 39 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
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| | | 245090 | B. WING _ | | l | / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 689 | and trying to stand sit with her one on as other residents in When interviewed of stated R1 had faller scream and throw hinterventions she know the low position and R1 did this she wou remembered R1 had area on her forehead but did not know who when interviewed of guardian stated the sustaining a fractur undiagnosed for so When interviewed of licensed practical in constantly throwing threatening to throw was not enough state supervision with R1 any assessment of determine why she was R1's behaviors assessment of R1's | up all the time, other than to one, winch was not possible required care too. on 9/24/20, at 1:31 p.m. NA-C in frequently, she would increel from bed. The only new of was to have the bed in indicate mats on the floor so when aldn't be injured. NA-C and a large swollen egg sized and had broken her finger, incent this occurred. on 9/24/20, at 3:07 p.m. R1's y were concerned about R1 ed finger that went | F 68 | 39 | | |
| | director of nursing (a good system for v are trying to improv | on 9/28/20, at 10:10 a.m. the (DON) stated they did not have when someone falls and they e this process. The nurse cident Review and Analysis | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED C | |
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| | | 245090 | B. WING _ | | 09 | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 689 | after each fall. The of these for R1's fa sustained on 7/14/2 9/15/20. The DON assessment had no other falls R1 sustaines and really rewhich they were unwas unable to providetermine if there what interventions anxiety/behaviors to frequently. No ass | age 21 be DON was only able to find 4 calls, which were for the falls 20, 7/31/20, 8/1/20, and a did not know why this bet been filled out for any of the ained. R1 had behavioral equired one on one attention, hable to provided. The DON hide any assessment to was a pattern to R1's falls, and may assist R1 with her hat led to her falling so essment had been completed o determine interventions that | F 68 | 9 | | |
| | included severe co diagnosis of demer disturbance. R4 rec mobility and dressi for transfer, toiletin was totally incontin cares 1-3 times du R3 had 1 fall withou assessment. R4's fall CAA includer/t having impaired psychotropic medic declined in both mo She has recently en | quired extensive assist for bed ng and total staff assistance g, and personal hygiene. R4 ent of bladder and rejected ring the assessment period. | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED C | | |
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| F 689 | narcotic, and psychincontinent of bower recent fall from bed for safety and keep R4's care plan date related to [blank]. So lowest position. Ca Follow PT and OT function." The mos "Ambulate to dining walker] support with 120 ft [feet] x1 [with was added 7/22/20 been made. R4's nursing assist "Assist of 2 w/ [with not ambulate; fall mat was in place included, "At 7:35 plying on floor next to agitated/anxious ar stand/yell at staff. Further when trying to position sing so resident as Ax2 [assist of 2 stafall mat was in place lowest position; roo lit." "Resident receis Seroquel [antipsychagitation/anxiety and following hour. Hos of nursing], and emnotified. Writer and about in-facility fam | ant Care Sheet included, not call light within reach and said staff with process and continued to monitor call light within reach; and so and | | 9 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION | | TE SURVEY MPLETED C |
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| | | 245090 | B. WING | | 09 | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | contact thought it w Emergency contact visit tomorrow." When interviewed oregistered nurse (R incident report or portall. R4's care plan R4, as she is no lor When interviewed of family member (FM allowed to visit relaced concerned about R would not be able to a visit. No one had possibly visiting to or When interviewed of LPN-D stated R4 h rolling from bed. To to the bed and make reach. LPN-D stated use the call light an intervention. When interviewed of stated, R4 was to h visits after this fall to the plan, and communing the communicated to the plan. The facility w plans. R3's admission MD | ould be worth a try; is going to try and stop for a on 9/28/20, at 10:00 a.m. N)-A stated there was no ost fall follow-up report on R4's was incorrect about walking ager able to ambulate. On 9/28/20, at 11:35 a.m. I)-B stated they had not been ted to COVID and was 4's falls. FM-B stated R4 osee them out her window for spoken to them about decrease anxiety. On 9/28/20, at 12:35 p.m. and fallen a couple times, they put a mat on the floor next e sure R4 has her call light in ed R4 would not know how to d was unsure why that was an on 9/28/20, at 3:05 p.m. RN-A ave increased family window on aide in preventing more falls. The interdisciplinary team should and update care sheets and care cate the change, but the | | 89 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING _ | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | , | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
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| F 689 | extensive staff assidaily living (ADL's), of falls prior to admadmission with no idelusions or hallucing R3's falls CAA date triggers for falls r/t history of falls, and Resident has had a following hospitalizweakness. He had increased right side OT at this time with community. Resider/t daily antihyperte and hypoglycemic of bowel and bladd vision, and hearing of falls prior to admission, follow therapy recowould be complete. R3's Fall Review Eincluded a checklis before admission, fuse that can increadeficits, incontinent concerns with balafindings or indication factors would be acceptable. R3's care plan date related to lack of safety. | and dementia. R3 required istance with most activities of was unsteady, had a history ission and had fallen since injury. R3 did not have inations. 2d 8/19/20, included, "Resident having impaired balance, daily antidepressant use. a recent decline in mobility ation for increased overall I a CVA [stroke] and has e weakness. He is in PT and in the goal of returning to the ent is at increased risk of falls insive, psychotropic, diuretic, medications. He is incontinent er. He has impaired cognitive, and Resident does have a history insision and has had one fall here he was reaching for loor. Plan to continue to keep call light in reach, and mmendations. Care planning d. Valuation dated 8/15/20, to frisk factors including fall fall after admission, medication are falls, cognition and sensory ce, confined to chair, and ince. There was no analysis of on on how any of these risk | F 68 | 9 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X: | | TION 'IDENTIFICATION NUMBER: ' | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | 09 | C / 28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP (27 BRAND AVENUE FARIBAULT, MN 55021 | · · · · · · · · · · · · · · · · · · · | 72072020 | |
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| F 689 | Answer call light pr for transfers, follow in reach, proper for items were in reach R3's progress note included, "Writer walked in and saw floor. Resident was eating supper. Aid resident up using has Resident states that dropped and he we his wheelchair. Re on the chair that was at the medicine "Pt [patient] was att RN heard some so his wheel chair and saw the resident far R3's progress note "Writer was called floor. Resident was and had his hands Resident was sitting up. Resident was atting up. Resident was for all transfers." | 'Staff were directed to, omptly, use a mechanical lift therapy instructions, call light otwear, ensue frequently used in. dated 8/10/20, at 9:31 p.m. as called into room when aid resident laying prone on the senext to wheelchair and was ADON and writer helped oyer [mechanical] lift. It he was eating and his spoon and to go catch it and fell out of sident states he hit his nose as next to the wheel chair." dated 8/22/20, at 6:55 p.m. as door was open and writer as cart adjacent to the room." tempting at self transfers and und that was apparently from an osooner than he turned, he | F 68 | 9 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | | C / 28/2020 |
| NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | sliding off edge of the R3's progress note "Resident was layin Resident was holding waiving it in the air. Tight next to him will resident states he his room and using out of his way. Resident while do there were no cats assessment of R3's room, even though or delusions at the assessment. When interviewed of LPN-C stated other care plan, no new in any post fall assess. The facility had not determine root cause prevent the falls frow increased confusion not assessed other which the family desinterdisciplinary tean next day and place that assessment, brown and RN-A state to provide the docuresident's who had facilities, "Risk mar | _ | F6 | 89 | | |

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| - 09/28/2020 |
| TE, ZIP CODE |
| N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION DATE D TO THE APPROPRIATE CIENCY) |
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| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | l ` ′ | | COMP | COMPLETED | |
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| | 245090 | B. WING _ | | | 8/2020 | |
| PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHO | OULD BE | (X5) COMPLETION DATE | |
| R10's nutritional stidentified a risk factorial diet. No analysis of completed. R10's care plan danutritional alteration meals; had diet result [National Dysphaging ground or are minorial pieces, they are meand could have reduirected to monitorial physician as needes swallowing problem. R10's undated nurrincluded mechanical R10's Nutrition Evaluated a mechanical meats. Speech the all meats ground, using the staff planting observation was observed to be 12:47 p.m. it was manburger patty of hard to eat becaus dentures in. She has the staff had gri | ropriate for diet upgrade. atus CAA dated 4/10/20, ctor of a mechanically altered of this risk factor was ated 4/1/20, included, risk for a related to coughing during strictions which included NDD2 ia Diet, level 2- meats are to be deed no larger than 1/4 inch oist, with some cohesion] diet quested puree. Staff were and for signs and symptoms of ms. sing assistant Care Guide all soft diet with pureed meat. aluation dated 4/16/20, aluation dated 4/16/20, aluation dated 4/16/20, aluation dated 4/16/20, aluation dated 7/14/20, full upper and lower dentures. To on 9/25/20, at 12:42 p.m. R10 aluation dated R10 was eating a regular a bun. R10 stated it was see she did not have her and requested the regular patty alled out the burgers and she | | 39 | | | |
| | PROVIDER OR SUPPLIER NT MANOR LLC SUMMARY ST. (EACH DEFICIENCE REGULATORY OR I Continued From pa R10 would be appl R10's nutritional st identified a risk fact diet. No analysis of completed. R10's care plan da nutritional alteratio meals; had diet res [National Dysphag ground or are mino pieces, they are m and could have red directed to monitor physician as neede swallowing probler R10's undated nur included mechanic R10's Nutrition Eva identified a mecha meat. Speech the all meats ground, u for preference." R10's Oral/Dental indicated R10 had During observation was observed to b 12:47 p.m. it was r hamburger patty o hard to eat becaus dentures in. She h as the staff had gri | PROVIDER OR SUPPLIER NT MANOR LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 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. R10's Nutrition 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 | ROVIDER OR SUPPLIER NT MANOR LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 | ROVIDER OR SUPPLIER NT MANOR LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 undated nursing assistant Care Guide included mechanical soft diet with pureed meat. R10's Undated nursing assistant Care Guide included mechanical soft diet with pureed meat. R10's Undated nursing assistant Care Guide included mechanical soft diet with pureed meat. R10's Undated nursing assistant Care Guide included mechanical soft diet with pureed meat. 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 | FORRECTION DENTIFICATION NUMBER: 245090 B. WING STREET ADDRESS. CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | IPLE CONSTRUCTION IG | | COMPLETED | |
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| | | 245090 | B. WING _ | | 09 | /28/2020 |
| PLEASANT MANOR LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 29 nor did anyone bring her dentures. | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| PRÉFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 689 | nor did anyone brir R10's lunch tray tic texture and to prov potato salad, no ra lettuce." When interviewed aide (DA)-A stated mechanical soft die with ground meat. she normally does When interviewed (CK)-A stated, a m ground meat, no bi cook is the person correct diet is serve When interviewed stated R10 does co unaware R10 did n stated if someone should go get a nui in the dining room. When interviewed stated she normally today got a regular grilling them. R10 dentures, but forgo have to remind her them. At 1:39 p.m. asked her if she wa | cket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating. on 9/25/20, at 1:12 p.m. cook echanical soft diet should have read or hard vegetables. The responsible to ensure the ed. on 9/25/20, at 1:21 p.m. NA-Fough at meals, she was not have dentures in. NA-Fis coughing like that, they rese to assess if no nurse was on 9/25/20, at 1:34 p.m. R10 by gets a ground burger, but whole burger as they were stated she normally wore her of them today. Staff sometimes to put them in or help her with R10 was coughing and NA-Has ok. | | 39 | | |
| | wished for an upgra | ets could be upgraded if they ade, but would have to sign a s statement. R10 did not have | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245090 | B. WING | | | C 09/28/2020 | |
| | PROVIDER OR SUPPLIER | | | 27 | REET ADDRESS, CITY, STATE, ZIP CODE BRAND AVENUE RIBAULT, MN 55021 | <u> U91.</u> | 20/2020 |
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| F 689 | a risk versus benef she given the risks a regular hamburge. When interviewed of Cook-A stated they who had signed a risk for a diet upgrade, they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Griconsistency and papureed food if desir when interviewed or registered dietician coughing during a risk beand a form signed. When interviewed of the DON, food servitherapy. This had infacility should not pidiet without risks beand a form signed. When interviewed of DON and RN-A state correct diet text swallowing problem if a resident is coughing a resident is coughing a resident is coughing the couple of the correct diet text swallowing problem if a resident is coughing a resident is coughing a resident is coughing a resident is coughing the couple of the cou | its statement signed nor was of choking when provided with er today. In 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the sordered and not a regular ion Form provided by Cook-A had been completed by dindicated R10 was to have a round Meat NDD2 diet tient could downgrade to red. In 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to rice director and speech not been done for R10. The rovide an upgraded texture eing explained to the resident on 9/28/20, at 2:37 p.m. the ted it is important to provide ture for residents with its. A nurse should be notified | F 6 | 889 | | | |
| | cognitive impairme | nt with diagnoses including, he MDS noted R5 had | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | TIPLE CONSTRUCTION NG | CON | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 720,2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 689 | swallowing medical period. The MDS further oversite, set up who altered textures. R5's Speech Theral indicated diagnoses and oral phase dysindicated R5 had must the evaluation had dentures that did now without dentures, R consistency solids and Advanced. R5 was of materials into the penetration (passagand/or asphyxiation) R5's Care Assessmedated 1/20/20, indicated 1/20/ | ing during meals or when tions during the assessment urther indicated supervision, en eating and mechanically by Evaluation dated 1/25/19, so of cerebral infarction (stroke) phagia. The evaluation further dissing teeth, and at the time of full upper and partial lower by the fit. The evaluation indicated to could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx, hence the Area Worksheet (CAA) cated R5 required a and diet. There was no analysis a noted to proceed to care and 3/20/20, indicated R5 was at literation related to chronic and diet restriction for NDD3 acted to monitor, document cian for signs or symptoms of | F 6 | 89 | | |
| | | aluation dated 9/4/20, identified D3, Dysphagia Advanced diet | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 245090 | B. WING | | 09/28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) | D BE | (X5) COMPLETION DATE |
| F 689 | and independent in from MDS 9/4/20, 0 physician order and R5's lunch tray tick. Dysphagia Advance further directed to phamburger on bun, vegetables, backed lettuce, soft ice credittuce, soft ice cre | et staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, dicare plan. et included a diet order for et diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw libeans, no bacon, shredded am and milk. ion on 9/25/20, at 12:50 p.m. able and was noted to cough heal. R5's plate contained a with a wedge of lettuce that on a bun and potato chips. Is staff throughout the dining ing and dietary, but no one of R5 was coughing. At 12:52 wed to be shaking and asked nurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A have received ground meat, dis soft cooked vegetables. R5 die a bun, the burger should and should not have received one leaf lettuce. on 9/25/20, at 1:10 p.m. R5 asional seizure that are like, of diet restrictions. | F 689 | | | |
| | | acility provided NDD3, NDD2 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | PLE CONSTRUCTION G | C C COMPLETED | | |
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| | | 245090 | B. WING _ | | | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 689 | have ground meat, For the noon meal mechanical texture ground hamburger was the cook's res resident is getting? When interviewed stated staff should coughing and should have received the who gave her the policy resident to the cook is recorrect diet. The facility Refusa and Benefits policy resident would be in benefits of necessary opportunity regardicare. The resident times and if resided documentation should be in the policy resident would be in the policy resident would be in the gave her the who gave her | no bread or hard vegetables. provided on 9/25/20, a e should have included, no bun, potato salad and beans. It ponsibility to make sure a the appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ald get a nurse. R5 should correct diet and did not know wrong diet. on 9/25/20, at 1:40 p.m. orted both dietary and nursing trays. on 9/25/20, at 3:06 p.m. RN-B is ok to be provided an a risk and benefit form had resident should be given the sician if there is no signed risk is did not have a signed form. p.m. Cook-A- stated R5 red the ordered diet, but did sponsible for providing the I of Care/Interventions, Risk of dated 9/11, identified a enformed of the risk and eary care and given the ing their decision in the plan of would be approached 2-3 int continued to refuse, buld be made on the Refusal of Risk and Benefits and | F 68 | 9 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED C | | |
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| | | 245090 | B. WING | | | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 689 | Dysphagia Mechan Level 1 are allowed | ge 34 nagia Diet indicated NDD2 as ically Altered. All foods on . Meats and other select and or minced into small pieces | F 68 | 9 | | |
| | no larger than one should be easy to do Moistened ground of fish. Moist ground with gravy or sauce pureed bread mixed and slurred breads thickness of products. Vegetable vegetables. Vegetables. | forth inch. All food items shew. Meats should be or cooked meat, poultry, or or tender meat may be served. Breads products can be s, moistened bread crumbs that are gelled through entire at and to avoid all other bread es should be soft, well-cooked ables should be less than 1/2 easily mashed with a fork. | F 72 | 5 | | 11/2/20 |
| | the appropriate con provide nursing and resident safety and practicable physica well-being of each resident assessme and considering the diagnoses of the fa | nt Staff. Ive sufficient nursing staff with inpetencies and skills sets to direlated services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care is number, acuity and cility's resident population in ine facility assessment required | | | | |
| | by sufficient number types of personnel nursing care to all r resident care plans | facility must provide services ers of each of the following on a 24-hour basis to provide esidents in accordance with : ived under paragraph (e) of | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | ` ′ | TIPLE CONSTRUCTION NG | COM | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | 09/28/2020 | | |
| | PROVIDER OR SUPPLIEF | ۲ | | STREET ADDRESS, CITY, STATE, ZIP C 27 BRAND AVENUE FARIBAULT, MN 55021 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 725 | this section, licens (ii) Other nursing limited to nurse ai §483.35(a)(2) Exc paragraph (e) of the designate a licens nurse on each tour this REQUIREMS by: Based on observing review, the facility staffing to provide planned needs for R1, R3, R8, R13 at LPN-A, LPN-D, NNA-A, RN-A, HSK members (FM)-A, This had the potensidents. Findings include: R5's quarterly Minincluded cognitive stroke with paraly the body and a sephysical assistant bathing. R5 Care Assessm 1/20/20, included, activities of daily land toileting. R5's care plan upneeded assistant shower/bath with services and services are plan upneeded assistant shower/bath with services are plantaged as a services | sed nurses; and personnel, including but not des. cept when waived under his section, the facility must sed nurse to serve as a charge | F 7 | F725=F. Based on observation and document review, the fensure sufficient staff to provide a residents, 12 of 15 staff, a family members, reviewed staff. This has the potential current residents. Pleasant Manor has the resprovide services by sufficient promote resident rights and The policy in regards to confacility Assessment has be and remains appropriate. The facility completed a fact assessment to assess and appropriate staffing needs for the level of care and provide gusture staffing needs for the level of care. Daily staffing will be signed off by Administrator of Nursing daily. Education will be completed through QAPI and with facil through an all-staff meeting executed facility assessment review of staffing. Administrator or designee waudits weekly x 4 weeks, mediate with the complete of the comp | facility failed to by the needs for 8 of and 1 of 3 for sufficient all to affect all 42 sponsibility to nt numbers to dignity. In the needs for the current and ance for a appropriate assignments strator or dignity and daily will perform | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ` ′ | PLE CONSTRUCTION | СОМ | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | | C 28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 20,2020 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 725 | checks. When interviewed of licensed practical in not getting the time toileting, bathing are enough staff. R5 d. When interviewed of stated, "This facility over an hour to get R5 stated it takes at the bathroom, and, Sunday and a show would rather I just to less time and effort because they say to less time and to wait for have enough staff to Sometimes they had on not have enough. When interviewed of licensed practical in complained of not go basis. This was up doing the best they. R5's Grievance/Co not receive a bath of stated, "R5's showed evening due to time did not get done due. | on 9/24/20, at 12:23 p.m. Jurse (LPN)-A stated, R5 was ally care she needed with and hygiene as there was not id complain about this. In 9/24/20, at 2: 20 p.m. R5 is very short staffed. I wait an answer to my call light." In long time to get help to go to "I should have a bath every wer every Wednesday. The aid ake a shower because it takes as Sometime, I get neither there are not enough aids on." to R5. In 9/24/20, at 3:22 p.m. and NA)-D stated R5 required hing and toileting, but often assistance as they do not so get to everyone timely. The stated R5 is bath as they in time. In 9/24/20, at 3:45 p.m. and surse (LPN)-B stated, R5 getting her shower on a regular is setting to her, but they were | F 725 | months, and quarterly the compliance. Audit results monthly at QAPI meetings recommendations. Completed: 11/2/2020 | will be reviewed | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED C | | |
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| | | 245090 | B. WING | | | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 725 | only two on the flood had a lot to do and time to get in the bas another shower that that we never got do Shower/bath record 2020: R5 received again until 8/17/20, 8/24//20. R5 received again until 9/21/20. Review of R5's cal p.m.) to 9/29/20 (2: the call light 166 time wait time was over 41.5% of the time. R7's admission MD moderate cognitive of a stroke. R7 was required assistance transfer on and off R7's ADL (activities Rehab Care Assest dated 9/25/20, included line in mobility, of bowel and bladd toileting upon requered assistance dependent assist, opersonal hygiene soccasionally incont with toilet use." | or until 6 p.m. After 6 we still ended up not having enough ath R5 wanted. There was also it was supposed to get done one." It dis dated July to September a shower on 7/19 but not and then not again until ed a bath on 9/13/20, but not I light log from 9/1/20 (6:53 24 p.m.), indicated, R5 used nes. Of the 166 instances, the 20 minutes on 69 occasions or as dated 7/28/20, included impairment with a diagnosis occasionally incontinent and a by one staff person to of the toilet. In of daily living)/Functional sment Area Worksheet (CAA) anded, R7 has had a recent was occasionally incontinent er, and needed assistance for | F 72 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING_ | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 27 BRAND AVENUE FARIBAULT, MN 55021 | | 720,2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 725 | nursing assistant (I week she found R7 when she started h was not enough startygiene needs in a When Interviewed was lying in bed. R facility is very bad. there seems to be facility. Call lights chour. I push the cal bathroom and no o wet myself. I feel h chair and embarras cleaned up and chabrow was furled an R7 stated this happ. When interviewed on ursing assistant (I wait for assistance her incontinent. Thi Most residents wait time to receive an a has assisted R7 aff secondary to waiting time for the call light that there have been beginning of the sh soiled and need as night shift is custom one licensed practionurse (RN) for the facility. | NA)-C reported the previous ' soiled halfway up her back er shift. NA-C reported there aff to meet R7's toileting and | | 25 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | | 09/28/2020 | |
| | PROVIDER OR SUPPLIER | | | 27 B | EET ADDRESS, CITY, STATE, ZIP CODE RAND AVENUE RIBAULT, MN 55021 | | 20/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 725 | morale among star of this. R7's call light resp 9/22/20, at 3:51 a. showed the call light seven day per initiated, 11 (or 21 15 minutes to receive a responsal of the seven day per initiated, 11 (or 21 15 minutes to receive a responsal of the seven day per initiated, 11 (or 21 15 minutes to receive a responsal of the seven day and limite the seven day and limite thygiene. R4 was was occasionally in times during the analysis of the seven with the seven dated 7/1/20 indicationary incontinence dated 7/1/20 indicationary incontinence." "Shand OT [occupation the goal of returning uses incontinence dry. Plan to continence dry. P | onse time logs dated from m. to 9/28/20, 9:25 a.m. tht was engaged 51 times over iod. Of the 51 call light alerts .5%) of these alerts took over eive a response. Seven (or ts took longer than 20 minutes | F7 | 725 | | | |

| | FOF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED C |
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| | | 245090 | B. WING_ | | 09 | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 725 | "Resident triggers toilet use and bladdeclined in both me She has recently elife cares. Residen aid in keeping skin current toileting pla [every] AM [mornin incontinent episode R4's only Bowel armedical record wark as continent of R4's care plan date "Alteration with elir to, "Assist of 1 with not been updated 8/27/20, MDS note incontinence to tot in assistance need hygiene. R4's nursing assist "Assist of 2 w/ Hoy ambulate." No informursing assistants toileting needs. During continuous starting at 10:34 a. if she would like to declined. No encorprovided. No additincontinence cares licensed practical rher room to check insulin. LPN-D their | for urinary incontinence r/t der incontinence. Resident has obility and cognitive function. nrolled in hospice for end of t uses incontinence products to dry. Plan to continue to with an and complete peri cares q ng], HS [night], and with each | | 25 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | I | | STREET ADDRESS, CITY, STATE, ZIP C 27 BRAND AVENUE FARIBAULT, MN 55021 | | 72072020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| F 725 | 1:58 p.m. NA-F and and changed R4's when interviewed and NA-B stated the morning cares at 7 not had time to assince getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge without being assis When interviewed director of nursing should be assisted hours. The DON sinceds very well. Right was present review and Bladder assess 6/24/20, noting it in bladder. RN-A revi identified R4 had not bladder assessment in June of 2020. RN-an updated assess change MDS compexplained they were R4 was on their work should have been of changed at least extended. | d NA-B assisted R4 into bed visibly wet brief. on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or toilet of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. on 9/28/20, at 3:05 p.m. the (DON) stated, she thought R4 with incontinent cares every 2 tated she did not know R4's egistered nurse (RN)-A who wed R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and of had an updated Bowel and int, even though she had a in condition since admission in A stated R4 should have had ment with the significant eleted in August 2020. RN-A is behind on assessments and rk list, "to be caught up." R4 checked for incontinence and very 2 hours. om 9/1/20 - 9/29/20 revealed th 20 times. Of the 20 time was over 10 minutes on r 40 minutes on one occasion, | F 7. | 25 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|--|------------|--|-------------------------------|---------------------|
| 245090 | | 245090 | B. WING | | | 1 | C 28/2020 |
| | NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC | | | 27 BRAND A | RESS, CITY, STATE, ZIP CODE AVENUE T, MN 55021 | | 20,2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | JST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION DATE | | |
| F 725 | R1's quarterly Minir 8/20/20, included, swith diagnoses inclinity) and dementi assistance with mo (ADL's) and did not falls with injury sinchad a discharge MIR1's care plan date AEB [as evidenced admission related to secondary to TBI and disturbances." The "Resident will be sashould incident occ "Provide one on on and wheeling her different 7/21/20 thorough had fallen in the frame. 7/14/20, 7/38/11/20, 8/12/20, 8/16/20, 8/19/20, 8/16/20, 8/19/20, 8/16/20 and 9/15/20 Hospital discharge indicated R1 was transferent switches and R1's progress notes revealed: | num Data Set (MDS) dated revere cognitive impairment uding TBI (traumatic brain a. R1 required extensive st activities of daily living ambulate. R1 had 2 or more e the prior assessment. R1 DS dated 9/16/20. d 9/2/20, included, "Fall risk by] multiple falls since to lack of safety awareness and Dementia with behavioral goal for R1 was listed as, afe and free from serious injury ur." Staff were directed to, e care, such as taking outside bown the hall." d a running list of R1's falls and 9/24/20, which indicated facility 17 times in that time 1/20, 8/1/20, 8/5/20, 8/6/20, 12/20, 8/16/20, 8/16/20, 12/20, 8/29/20, 9/3/20, 0. summary dated 9/16/20, ansferred to the hospital on ning a fall related to increased of details R1 incurred a | F 7 | 25 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | | C | |
| NAME OF | PROVIDER OR SUPPLIER | 243090 | b. WING | STREET ADDRESS, CITY, STATE, ZIP COD | | /28/2020 | |
| | INT MANOR LLC | | | 27 BRAND AVENUE FARIBAULT, MN 55021 | Ε, | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 725 | R1's progress note included R1 had at several times after Facility transferred started to yell out a and back. R1 reponeck and back. R1 wheelchair. Facility ratio as the facility R1's physician was confirmed for the hospital. R1's guar transfer situation. R1's progress note included, R1 was tfull report was give teams. The floor number inform that R1 was safety concerns. R1's progress note included, R1 was marked behaviors: put herself onto the louder than her usuand 1:1, 2:2, 3:3 wheremained aggressing 911 to send R1 to off further evaluation. When interviewed stated there were to one attention, but the cover a unit of 30 massible. | age 43 dated 9/16/20, at 5:35 p.m. tempted to crawl out of bed returning from the hospital. R1 to her wheelchair, R1 then and reported of pain in neck rted to facility of pain in her started to stand up from her initiated a 2 to 1 staff to R1 determined R1 was not safe. Contacted and consulted and R1 to be sent back to the dian was informed of the returning to the hospital. A not the police and transport curse called the hospital to returning to them due to returning to them due to returning and hollering and, R1 was extremely agitated ere attempted and R1 ve towards staff, attempted to be floor, yelling and hollering and, R1 was extremely agitated ere attempted and R1 ve towards staff. Facility called emergency department (ED) on per physician's orders. on 9/24/20, at 1:00 p.m. NA-B imes when R1 required one on hey only had one or two staff to residents, so this was not | F 7 | 25 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | COMPLETED | |
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| | | 245090 | B. WING | | 09 | /28/2020 |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 725 | all the time and she When interviewed emergency room s would not take R1 they did not have e enough. When interviewed stated R1 required time to prevent her not have the time to NA-D stated she w when arriving for h wet," in her incontin When interviewed stated there was no R1 and keep her sa attention. When interviewed DON stated due to could not be met a | on 9/24/20, at 2:56 p.m. the ocial worker stated the facility back to the facility because mough help to watch her well on 9/24/20, at 3:22 p.m. NA-D a significant amount of staff from falling and they just did o stay with her all the time. Torked the day shift and often er shift would find R1, "sopping | | 5 | | |
| | 8/15/20, revealed Fimpairment. R3 red staff physical assis diagnosis included swallowing concern mouth when eating mouth/cheeks or red | nimum data set (MDS), dated R3 had moderate cognitive quired supervision and one tance for eating. R1's a stroke. R3 had the following hs: loss of liquids/solids from g or drinking, holding food in esidual food in mouth after ng during meals or when | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING_ | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021 | • | |
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| F 725 | swallowing medical R3's care plan, lass staff, "The residen with adequate eati all meals in the dir supervision-not to is provided." When interviewed stated she worked "understaffed." Nabe provided morninespecially if they reassistance with me required individual not eat too quickly get enough fluid. Nover 40 minutes to in the dining room. When interviewed stated, R3 required make sure he atestaff were available around the room, with the continuous control of the c | t updated 9/24/20, directed to needs a calm, quiet meal timeing time. The resident requires ing room r/t [related to] close receive meals until supervision on 9/24/20, at 12:56 p.m. NA-A day shift and considered it, A-A reported residents waited to neg cares prior to breakfast, equired two staff and echanical lift. NA-A stated, R3 assistance for cueing him to or take too big of a bite and to lA-A noted R3 often had to wait eat until they had enough staff | F 72 | 25 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | l ` ′ | IPLE CONSTRUCTION IG | CON | (X3) DATE SURVEY COMPLETED | |
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| F 725 | When interviewed of stated there is never room to feed every | on 9/25/20, at 1:21 p.m. NA-Fer enough staff in the dining one. "On a good day, we are es to assist all the residents." | F 72 | 25 | | | |
| | was cognitively inta Parkinson's diseas assistance of 2 sta and one person ph R8's care plan, last staff, "Alteration in | PS, dated 8/10/20, included, R8 ct with a diagnosis of e. R8 required physical ff for transfers and supervision ysical assistance for toileting. revised 8/24/20, directed elimination r/t [related to] Assist of 1 with toileting as | | | | | |
| | LPN-A stated R8 w the morning and ne | on 9/24/20, at 12:23 p.m. as independent with cares in eded more assistance in the oted R8 might not even turn holler out for staff. | | | | | |
| | stated, "We barely more independent | on 9/24/20, at 12:56 p.m. NA-A touch base," with R8 as she is and staff need to help with ired more assistance. | | | | | |
| | stated there was no when she needed i with stiffness and d on her own when h | on 9/28/20, at 10:37 a.m. R8 of enough staff to help her t. R8 stated she has problems ecreased ability to do things er Parkinson's medication was ff tell her they have a half hour | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 725 | on each side of the but it is often over to they do not have end time. R8 stated should be attempted to the bathroom, she minutes to get on other back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and dated August 2020 Carbidopa-Levodop Parkinson's diseas stiffness, tremors, so control) five times of 4:00 p.m., 7:30 p.m. noted as being additional each opportunity, be not noted. When interviewed the LPN-D stated R8 witime. LPN-D stated R8 witime. LPN-D stated getting her medicated R8's call light log, coincluded, R13 activities incidents, the responsibility of the respo | time her medication is due, hat. R8 stated staff tell her nough staff to get it to her on e does not get enough help to often has to wait 20-40 or off the toilet. This causes d she gets even more still and herself even more. Iministration record (MAR), included an order for toa (a medication for treating e symptoms such as muscle spasms, and poor muscle daily; 5:55 a.m., 10:00 a.m., a. and 11:30 p.m. R8 was ministered the medications at the time administered was an event of the time administered was a reported concerns with the time in the evening. Interest 10 days 10:58 a.m. and 10 | F 72 | 5 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245090 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
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| F 725 | risk for skin breakd assistance. The cacall light in reach at When interviewed stated R13 was totacares. Sometimes breakfast as they dher up before breal up, but is agreeable Often R13 would be were able to attend When interviewed stated when comin they would find R13 often the only staff competent to use the get R13 up, and duin bed at supper tin they just didn't have her up. When interviewed stated she is incommedical condition, speriods of time to be addition, she ofte because there is not This was upsetting R13's call light logs reviewed. R13's call light logs reviewed. R13's call light logs reviewed. R13's call sight logs reviewed. R13's call light logs reviewed. | own and required staff are plan indicated to keep the and answer promptly. on 9/24/20, at 1:31 p.m. NA-C ally dependent on staff for R13 had to stay in bed for idn't have enough staff to get a when they need her to be. e., "saturated" by the time they to her after breakfast. on 9/24/20, at 3:22 p.m. NA-D g on for the afternoon shift a soaked in urine. NA-D was on afternoons who was ne mechanical lift needed to be to this, often R13 had to stay ne. This would upset R13, but a enough help to always get on 9/28/20, at 11:05 a.m. R13 tinent of urine due to her she often has to wait extended be changed in order to be dry, en is unable to get out of bed oft enough staff to help her up. | F 72 | 5 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245090 | | ` ′ | TIPLE CONSTRUCTION ING | | (X3) DATE SURVEY COMPLETED C | |
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| | NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC | | | STREET ADDRESS, CITY, STATE, ZIF 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
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| F 725 | R12's quarterly MD R12 had moderate was on hospice ser care. R12's diagnost disease, asthma/ch disease or chronic failure. R12's medication a report (MAR/TAR), staff, "Connect 02' bedtime." and "Oxy cannula while at resmarked as complete 9/17/20. The MAR/has bipap on every cpap placement. Plevery hour overnight completed on 9/4/2 "Bipap-Nurse must sleeping and at nigh completed the nigh On 9/24/20, at 3:45 family had concern was, "slower," and residents. On 9/25/20 at 10:38 R12, (FM)-A stated through video. R12 and oxygen nasal cassist with respirate would notice times | S dated 8/14/20, included, cognitive impairment. R12 vices and required oxygen ses included coronary artery ironic obstructive pulmonary lung disease and respiratory and treatment administration dated August 2020, directed 1.5 L [liters]/min [minute] at gen at 1.5L/min per nasal st and at night. This was not ed on the night of 9/4/20 and TAR directed "Ensure resident overnight, every night shift for ease ensure Cpap is in place nt." This was not marked as | F 7 | 725 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245090 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 09/28/2020 | |
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| | PROVIDER OR SUPPLIER | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | , | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 725 | reported, during the the facility to alert set the interview, R12 when she was not eneeded, like she was R12 was deteriorate physically and was the oxygen. FM-As she noted no came movement detected 11:34 p.m. and 4:00 required frequent in was on properly. Flyshe felt like a burde had informed the disconcerns and there improvement. R12's call light log, included, R12 active Eleven of those we minutes. Six were a minutes. S | lige 50 lese instances, she would call staff, without response. During moted she did not feel well getting the oxygen she as in a "daze". FM-A reported ing both cognitively and more confused when not on stated, on 9/18/20 to 9/19/20 are activity, indicating no did, in R12's room between 9 p.m. FM-A noted R12 monitoring to ensure her bipap M-A reported R12 had told her en to staff. FM-A reported she irector of nursing of her ewas no resolution or dated 9/1/20 to 9/29/20, lated the call light 66 times. It is answered between 30 to 40 answered between 30 to 40 answered between 40 and 50 answered in over 60 minutes on 9/24/20, at 12:23 p.m. were not enough staff to care A explained there were a aide on west side of the care were not getting the timely care mely toileting, bathing and oad was stressful and in burnout and turnover. LPN-A cussed concerns with DON and there had been no eported she helped the with cares when she was able completing treatments and | F 725 | | | |

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| F 725 | medication pass for there was an overar getting the timely an hygiene. When interviewed reported she was passistant duties to appointments and sufficient nursing speri-cares for reside busy with their own time baths and shoresidents were not evening cares when chart a resident refundant had not been offered bathed, when they been reported to be with no changes. When interviewed stated she worked times when she worked times when she worked times resident extended periods of hour. They just comeal times resident sheen reported to the there was nothing to when interviewed stated there was or residents. Nurses personal cares for addition to their regards. | age 51 In residents. LPN-A reported all concern with resident not ssistance with bathing and on 9/24/20, at 1:31 p.m. NA-C pulled away from her nursing help with electronic medical wound rounds. There was not taff to provide oral care and ents. The nurses were too a duties to assist. Most of the owers were missed and assisted with morning and in they preferred. Staff would fused a bath, when the resident ed, or chart a resident was were not bathed. This had both the DON and administrator on 9/24/20, at 3:22 p.m. NA-D the night shift and there were build be the only nurse aid in the call lights were on for of time- sometimes over an uld not get to them timely. At its complain of cold food, daily occurrence." This had be administrator but was told they could do about it. On 9/24/20, at 3:45 p.m. LPN-B ne or two aides for 30 were expected to provide 5 residents each shift in gular duties. Sometimes, they ake sure resident treatments | F 72 | 5 | | |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | IPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED C 09/28/2020 | |
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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP OF 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 720/2020 |
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| F 725 | staffing agency, the they do not have en their work. LPN-B management and with the work. LPN-B management and with the staff not meet resided. When interviewed administrator, assist RN-A were intervie facility assessment staffing needs to mneeds. Typically, the staff nave manoticed "a lot of staff administrator noted dynamics and cultus staffing concerns. was committed to it and chipping in with she felt there was a but felt the communication many staff and reported there was too many staff and reported there was consus was down. The facility staffing staff, "Our facility p staff with the skills provide care ad set accordance with resident and the staff and reported there was consus was down. | bey are reluctant to return as an ough time to complete all of had reported this concern to was told they had enough staff. on 9/25/20, at 11:12 p.m. ing assistance seem to be, use they do not have enough | F 72 | 25 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | X3) DATE SURVEY COMPLETED C | |
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| F 725 | requirements of direction by the needs of the resident's plan of care | ect care staff are determined residents based on each are." | F 725 | 5 | | | |
| | Food in Form to Me CFR(s): 483.60(d)(s) §483.60(d) Food ar Each resident received with resident secondaric with residents (R5 and Food field texture die Findings include: R10's quarterly MD cognitively intact will lung disease. R10 up assistance with R10's Speech Therincluded a diagnosidysphagia (difficulty throat) and oral phasin the mouth). The risk for aspiration or Recommendations consistency, small (chewing), swallow bite/sip, slow pacing | set Individual Needs (3) and drink (2) wes and the facility provides— I prepared in a form designed (2) prepared in a form designed (2) prepared in a form designed (2) prepared (3) prepare food in (3) prepare food in (3) previewed (4) prepare food in (4) previewed (4) prepared | F 805 | F805=D. Based on observation, interview, and document review, the facility failed to prepare food in accordance with residents needs for 3 residents reviewed and required modified texture diets. Pleasant Manor residents have the receive food prepared in a form desto meet their individual needs. Plea Manor staff have a responsibility to monitor and ensure that the resider receive food prepared in a form to a their individual needs. The associated policies related to a appropriate diet texture have been reviewed and remain appropriate. All residents diet textures were reviand remain appropriate. All physicion orders match culinary meal card sy Education was provided to all staff regarding serving appropriate modidiet textures during meal time. Culinary Director/Dietitian or design | right to signed as ant ints meet serving ewed ian estem. | 11/2/20 | |
| | included a diagnosi dysphagia (difficulty throat) and oral pha in the mouth). The risk for aspiration o Recommendations consistency, small (chewing), swallow bite/sip, slow pacing between liquids/sol | s of pharyngeal phase y swallowing for issues in the use dysphagia (due to issues evaluation noted R10 was at f food or fluids. were made for puree bites thorough mastication bites before taking another | | The associated policies related to sappropriate diet texture have been reviewed and remain appropriate. All residents diet textures were reviand remain appropriate. All physiciorders match culinary meal card sy Education was provided to all staff regarding serving appropriate modidiet textures during meal time. | ewed ian rstem. fied nee will nonthly | | |

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| F 805 | R10's nutritional state identified a risk fact diet. No analysis of completed. R10's care plan dain nutritional alteration meals; had diet rest [National Dysphaging ground or are minor pieces, they are more and could have requirected to monitor physician as needes swallowing problem. R10's undated nursincluded mechanical statements. Speech there all meats ground, ufor preference." R10's Oral/Dental Eindicated R10 had sure observed to be 12:47 p.m. it was not hamburger patty or hard to eat because | opriate for diet upgrade. atus CAA dated 4/10/20, tor of a mechanically altered f this risk factor was ted 4/1/20, included, risk for n related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be ed no larger than 1/4 inch bist, with some cohesion] diet uested puree. Staff were document, and report to the ed for signs and symptoms of | F 805 | ensure compliance. Audit res reviewed monthly at QAPI me further recommendations. Completed 11/2/2020 | | |

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| F 805 | nor did anyone bring R10's lunch tray tick texture and to prove potato salad, no ravilettuce." When interviewed aide (DA)-A stated mechanical soft die with ground meat, she normally does. When interviewed (CK)-A stated, a meground meat, no brown correct diet is served. When interviewed stated R10 does con unaware R10 did not stated if someone is should go get a nur in the dining room. When interviewed stated she normally today got a regular grilling them. R10 dentures, but forgo have to remind her them. At 1:39 p.m. asked her if she was | ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating. on 9/25/20, at 1:12 p.m. cook echanical soft diet should have read or hard vegetables. The responsible to ensure the ed. on 9/25/20, at 1:21 p.m. NA-Fough at meals, she was of have dentures in. NA-Fough at meals, she was of have dentures in. NA-For se coughing like that, they rese to assess if no nurse was on 9/25/20, at 1:34 p.m. R10 or gets a ground burger, but whole burger as they were stated she normally wore her to put them in or help her with R10 was coughing and NA-Has ok. | F 80 | 5 | | |
| | stated resident's di wished for an upgra | on 9/25/20, at 3:06 p.m. RN-B ets could be upgraded if they ade, but would have to sign a statement. R10 did not have | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| F 805 | a risk versus benefishe given the risks a regular hamburg. When interviewed Cook-A stated they who had signed a risk for a diet upgrade, they can provide it. these. R10 should ground meat diet a hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Ground consistency and papureed food if desired without risks be and a form signed. When interviewed registered dietician coughing during a the DON, food service the pool of the p | fits statement signed nor was of choking when provided with er today. on 9/25/20, at 3:08 p.m. have a file of each resident risk versus benefits statement then if they ask for an upgrade. R10 did not have one of have been provided the is ordered and not a regular tion Form provided by Cook-A had been completed by dindicated R10 was to have a round Meat NDD2 diet atient could downgrade to red. on 9/28/20, at 10:21 p.m. the in (RD) stated if a resident were meal it should be reported to vice director and speech not been done for R10. The provide an upgraded texture eing explained to the resident on 9/28/20, at 2:37 p.m. the ated it is important to provide ture for residents with ins. A nurse should be notified | F 80 | 05 | | |
| | cognitive impairme | S dated 9/4/20, indicated no ent with diagnoses including, The MDS noted R5 had | | | | |

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| F 805 | coughing and chok swallowing medicate period. The MDS for oversite, set up who altered textures. R5's Speech Thera indicated diagnoses and oral phase dys indicated R5 had more than the evaluation had dentures that did now without dentures, R consistency solids and Advanced. R5 was of materials into the penetration (passage and/or asphyxiation R5's Care Assessmedated 1/20/20, indicated 1/20 | ing during meals or when a cions during the assessment arther indicated supervision, an eating and mechanically by Evaluation dated 1/25/19, as of cerebral infarction (stroke) phagia. The evaluation further dissing teeth, and at the time of full upper and partial lower by the fit. The evaluation indicated and recommended Dysphagia at risk of aspiration (passage a vocal cords), laryngeal ge of materials into the larynx, but the the fit of the fit of the fit of the distribution of the fit of | F 80 | | | |

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| | | 245090 | B. WING _ | | 09 | C / 28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 27 BRAND AVENUE FARIBAULT, MN 55021 | | 72072020 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 805 | R5's Care guide for and independent in from MDS 9/4/20, 0 physician order and R5's lunch tray tick. Dysphagia Advance further directed to phamburger on bun, vegetables, backed lettuce, soft ice credibuting an observat R5 sat alone at a tawhile she ate her myhole hamburger was covered the burger. There were various area including nurs stopped to see why p.m. R5 was obserfor someone get a having a seizure. Sof the dining room. When interviewed of stated R5 should have has should not have has serviced and should not have has serviced and serviced stated R5 should have has should not have has serviced and serviced servi | et staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, dicare plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw I beans, no bacon, shredded am and milk. ion on 9/25/20, at 12:50 p.m. able and was noted to cough heal. R5's plate contained a with a wedge of lettuce that on a bun and potato chips. It is staff throughout the dining ing and dietary, but no one of R5 was coughing. At 12:52 wed to be shaking and asked nurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A ave received ground meat, dietary, the burger should and should not have received | F 80 | 05 | | | |
| | stated she has occ "spells," and has no When interviewed of Cook-A stated the t | on 9/25/20, at 1:10 p.m. R5 asional seizure that are like, o diet restrictions. on 9/25/20, at 1:12 p.m. facility provided NDD3, NDD2 as. A mechanical diet should | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|--|-------------------------------|----------------------------|
| | | 245090 | B. WING | | | 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 805 | have ground meat, For the noon meal mechanical texture ground hamburger, was the cook's respresident is getting to the cook's respresident is getting to the cook's respresident is getting to the cook is respected to the c | no bread or hard vegetables. provided on 9/25/20, a should have included, no bun, potato salad and beans. It consibility to make sure a he appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ld get a nurse. R5 should correct diet and did not know wrong diet. on 9/25/20, at 1:40 p.m. orted both dietary and nursing trays. on 9/25/20, at 3:06 p.m. RN-B ok to be provided an a risk and benefit form had esident should be given the sician if there is no signed risk 5 did not have a signed form. p.m. Cook-A- stated R5 ed the ordered diet, but did sponsible for providing the of Care/Interventions, Risk dated 9/11, identified a nformed of the risk and any care and given the ng their decision in the plan of would be approached 2-3 at continued to refuse, uld be made on the Refusal of Risk and Benefits and | F 805 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZII 27 BRAND AVENUE FARIBAULT, MN 55021 | | 20/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 805 | The National Dysph Dysphagia Mechan Level 1 are allowed foods may be groun no larger than one is should be easy to complete Moistened ground of fish. Moist ground with gravy or sauce pureed bread mixed and slurred breads thickness of products. Vegetable vegetables. Vegetable | ge 60 nagia Diet indicated NDD2 as ically Altered. All foods on . Meats and other select and or minced into small pieces forth inch. All food items hew. Meats should be or cooked meat, poultry, or or tender meat may be served and a Breads products can be as, moistened bread crumbs that are gelled through entire at and to avoid all other bread as should be soft, well-cooked ables should be less than 1/2 easily mashed with a fork. | F 8 | 05 | | |

PRINTED: 11/02/2020 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC SIMPLE (RECHI DEFICIENCE) FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES FARIBAULT, MN 55021 FROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) FOUND INITIAL COMMENTS 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 to conduct a complaint investigation. Your facility see found to be substantiated: H5090059C at F677, F686 and F725 The following complaints were found to be unsubstantiated: H5090055C and H5090058C. The facilitys 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 550 Resident Rights/Exercise of 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. | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--|---------------------|---|--|------------|
| PLEASANT MANOR LLC PRESIDENT MANOR LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) FREET MANOR CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) FOUND 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: H5090055C at F689 H509005FC at F687 and F725 H5090059C at F677, F686 and F725 H5090059C, or spignature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PCC will be used as verification of compliance with 42 complaints were enrolled in ePCC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PCC will be used as verification of compliance with the regulations has been attained in accordance with your verification. F.550 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) S483.10(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. | | | 245090 | B. WING | | | |
| FREERY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD 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 complaine with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5090055C 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 550 Resident Rights/Exercise of Rights SR=D CFR(s): 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. | | | | | 27 BRAND AVENUE | <u>, </u> | |
| 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: H5090058C 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 550 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. | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP |) BE | COMPLETION |
| self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. | F 550 | On 9/24/20, 9/25/2 survey was complete complaint investigation to be in compliant Requirements for L. The following composubstantiated: H5090056C at F68/200057C at F67/200059C at He bottom of the form. Your electronia be used as verificated Upon receipt of an accomposite revisit of your validate that substant regulations has been your verification. Resident Rights/Ex CFR(s): 483.10(a) (9/200059C) | 0 and 9/28/20, an abbreviated ted at your facility to conduct a tion. Your facility was found ince with 42 CFR Part 483, ong Term Care Facilities. Ilaints were found to be 7 and F725 7, F686 and F725 Ilaints were found to be 5090055C and H5090058C. If correction (POC) will serve our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance. acceptable electronic POC, an aur facility may be conducted to ntial compliance with the en attained in accordance with ercise of Rights 1)(2)(b)(1)(2) | | | | 11/2/20 |
| | | self-determination, access to persons a outside the facility, this section. | and communication with and and services inside and including those specified in | | | | |

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

(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.

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|--|-------------------------------|--|
| | | 245090 | B. WING | | C 09/28/2020 | |
| | PROVIDER OR SUPPLIER | | : | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | 1 00/20/2020 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE COMPLÉTION | |
| F 550 | with respect and digresident in a manner promotes maintenather quality of life, reindividuality. The fapromote the rights of \$483.10(a)(2) The access to quality caseverity of condition must establish and practices regarding provision of service residents regardles §483.10(b) Exercise The resident has the rights as a resident or resident of the U §483.10(b)(1) The free interference, coercifrom the facility. §483.10(b)(2) The free of interference reprisal from the facility. §483.10(b)(2) The free of interference reprisal from the facility. This REQUIREMENT by: Based on observatoreview, the facility for the | cility must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and of the resident. Facility must provide equal are regardless of diagnosis, in, or payment source. A facility maintain identical policies and transfer, discharge, and the is under the State plan for all is of payment source. The of Rights is eright to exercise his or her of the facility and as a citizen inted States. The color of the right without on, discrimination, or reprisal are sident has the right to be in coercion, discrimination, and cility in exercising his or her ported by the facility in the er rights as required under this interview, and document ailed to provide care in a ted dignity for 1 of 1 resident in a ted dignity for 1 of 1 resident. | F 550 | F550=D. Based on observation, interview, and document review, the facility failed to provide care in a methat promoted dignity for 1 of 1 research (R7) reviewed for dignity concerns. | anner ident | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | LE CONSTRUCTION | ` ´COM | E SURVEY PLETED |
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| | | 245090 | B. WING | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE TO BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 550 | 7/28/20, included myith a diagnosis of incontinent and requerson to transfer of R7's ADL (activities Rehab Care Assest dated 9/25/20, includedine in mobility, of bowel and bladditoileting upon requered assistance dependent assistance was lying in bed. R'facility is very bad. there seems to be a facility. Call lights chour. I push the call bathroom and no owet myself. I feel in chair and embarras cleaned up and chabrow was furled and R7 stated this happ. When interviewed on ursing assistant (Now was for assistance) | nimum Date Set (MDS) dated noderate cognitive impairment a stroke. R7 was occasionally uired assistance by one staff on and off of the toilet. of daily living)/Functional sment Area Worksheet (CAA) uded, R7 has had a recent was occasionally incontinent er, and needed assistance for | F 550 | The residents of Pleasant Manoright to receive care in a dignifical it is the responsibility of all staff facility to ensure the residents' process care promotes their dignity and rights. The associated policies related providing care in a dignified manareviewed and remain appropriate R7's plan of care for toileting was reviewed and remains appropriate currently level of function. All restoileting plans have been reviewed discussed as an IDT and toileting appear to be appropriate at this additionally will implement a Readvocate Program that will assi promoting timely response to reconcerns. Education of executing a toileting care will be completed for all nuture and IDT will be educated on Readvocate Program. Administrator/DON or designed perform audits weekly x 4 week x 3 months, and quarterly therefore ensure compliance. Audit result reviewed monthly at QAPI meet further recommendations. Date of completion: 11/2/2020 | ed manner. of the olan of resident to nner were te. as ate for esident's ved, ng plans time. IDT sident st in esident will s, monthly after to s will be | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | PROVIDER OR SUPPLIER | | | 27 | REET ADDRESS, CITY, STATE, ZIP CODE BRAND AVENUE ARIBAULT, MN 55021 | | 0.2020 | |
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| F 550 | time to receive an a has assisted R7 aft secondary to waitin time for the call light that there have been beginning of the sh soiled and need as night shift is custom one licensed practionurse (RN) for the a facility. When interviewed of LPN-D state there individual needs of among staff and rear R7 being incontiner to her timely is a digital R7's call light responsible to her timely is a digital R7's call light responsible to her timely is a digital R7's call light responsible to her timely is a digital R7's call light responsible to her timely is a digital R7's call light responsible to her timely is a digital R7's call light responsible to her timely is a digital R7's call light responsible to her timely is a digital R7's call light responsible to her timely is a digital R7's call light responsible to her timely is a digital R7's call light responsible to her timely is a digital R7's call light responsible to her timely a facility as determining a phone call p.m. the administrator stated include one staff machinistrator stated include | a for an extended period of answer to their call light. NA-D are R7 was incontinent g for a prolonged period of at to be answered. NA-D stated an, "too many times," at the lift when several residents are asistance. NA-D stated the narily staffed with two NA's and cal nurse (LPN) or registered 42 current residents in the on 9/25/20, at 2:55 p.m. In the light and the leach resident. The morale sidents is low because of this and the leach resident. The morale sidents is low because of this and the leach resident and the leach resident. The morale sidents is low because of this and the leach resident and the leach resident. The morale sidents is low because of this and the leach resident. The morale sidents is low because of this and the leach resident. The morale sidents is low because of this and the leach resident and light alerts (leach light alerts (lea | F 5 | 550 | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION | | PLETED |
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| F 625 SS=D | CFR(s): 483.15(d)(§483.15(d) Notice of §483.15(d)(1) Notice of sursing facility transithe resident goes of nursing facility must the resident or residence of the resident or residence of the resident of the any, during which the return and resume facility; (ii) The reserve been plan, under § 447.4 (iii) The nursing fact bed-hold periods, where the plan is section. §483.15(d)(2) Bed-the time of transfer hospitalization or the facility must provide resident represental specifies the duration described in paragraph by: Based on document facility failed to issue the surseries of the described in paragraph by: | of bed-hold policy and returnate before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the trovide written information to dent representative that the state bed-hold policy, if the resident is permitted to residence in the nursing a payment policy in the state of of this chapter, if any; ility's policies regarding which must be consistent with this section, permitting a send in specified in paragraph (e)(1) thold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the ative written notice which can of the bed-hold policy saph (d)(1) of this section. Note that the section is not met as evidenced and review and interview, the lea written bed-hold notice is hospital for 1 of 3 residents | F 625 | F625=D. Based on document reinterview, the facility failed to issurantee bed-hold notice upon transtee the hospital for 1 of 3 residents (reviewed for hospitalizations. Prior to transfer, it is the responsithe Pleasant Manor staff to offer | eview and ue a nsfer to R1) | 11/2/20 |

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| F 625 | R1's admission Min 5/20/20, indicated F 5/14/20 with a dischanticipated MDS da R1's progress note included, R1 was trafull report was giver teams. However a hin R1's medical recommendation when interviewed of guardian reported shed hold notification possibility to hold the | imum Data Set (MDS) dated R1 was admitted to facility on harge assessment-return ated, 9/16/20. dated 9/16/20, at 6:24 p.m. ansferred to the hospital and a not the police and transport ped hold notice was not found ord. on 9/24/20, at 3:07 p.m. R1's the had not been provided a not and was unaware of the | F 63 | bed-hold to the resident being The bed-hold policy has been and remains appropriate. All nurses and IDT members educated on the bed-hold polisteps to carry out offering a beduring a transfer to the hospit Administrator or designee will audits weekly x 4 weeks, mon months, and quarterly thereaf compliance. Audit results will monthly at QAPI meetings for recommendations. Completed 11/2/2020 | reviewed will be cy and the ed-hold al. perform thly x 3 ter to ensure be reviewed | |
| F 677 SS=D | Facility policy titled, Emergency revised bullet number 4: "The responsible for: b. or her representative readmission appeared." ADL Care Provided CFR(s): 483.24(a)(2) A responsible for: b. or her representative readmission appeared." ADL Care Provided CFR(s): 483.24(a)(2) A responsible for: big services to maintain personal and oral her this REQUIREMENT by: Based on observations. | ident who is unable to carry y living receives the necessary n good nutrition, grooming, and | F 6 | F677=D. Based on observation interview, and document review. | | 11/2/20 |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION | | E SURVEY PLETED |
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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, 27 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 20/2020 |
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| F 677 | status after a signi residents (R3) revidents (R3) revidents (R3) revidents (R4's admission Mi 6/29/20, included, with diagnoses incarthritis. R4 requilito to t | age 6 illed to reassess continence ficant change for 1 of 3 fewed for incontinence. nimum Data Set (MDS) dated moderate cognitive impairment cluding diabetes, dementia and red extensive assistance with d assistance with personal not on a toileting program and ncontinent of urine (less than 7 ssessment period). Care Area Assessment (CAA) ated, "Resident triggers for the r/t [related to] need for let use and bladder e is in PT [physical therapy] and therapy] at this time with must be to with current toileting plan cares q [every] AM [morning], h each incontinent episode." ange MDS dated 8/27/20, angitive impairment, was totally taff for toileting and personal always incontinent of urine. CAA dated 8/28/20 included, for urinary incontinence r/t der incontinence. Resident has obility and cognitive function. enrolled in hospice for end of at uses incontinence products to a dry. Plan to continue to with | F6 | facility failed to provide itimely, and failed to reastatus after a significant residents (R4) reviewed Pleasant Manor staff haresponsibility to provide who are unable to carry daily living to promote the including assessment dand providing care daily The associated policies plans have been review appropriate. R4's toiletter reviewed and updated. toileting plans have been discussed as an IDT and appear to be appropriate. Staff will be educated on toileting plans per plant of DON or designee will perweekly x 4 weeks, montand quarterly thereafter compliance. Audit result monthly at QAPI meeting recommendations. Completed 11/2/2020 | sess continence change for 1 of 3 for incontinence. We the care to residents out activities of heir health, related to toileting ed and remaining plan was all resident's not reviewed, doubt toileting plans eat this time. In executing of care, erform audits they x 3 months, to ensure its will be reviewed. | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245090 | B. WING _ | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COE 27 BRAND AVENUE FARIBAULT, MN 55021 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 677 | [every] AM [mornin incontinent episode R4's only Bowel and medical record was R4 was continent of R4's care plan date "Alteration with elinato, "Assist of 1 with not been updated as 8/27/20, MDS note incontinence to total in assistance need hygiene. R4's nursing assist "Assist of 2 w/ Hoy ambulate." No information assistants tolleting needs. During continuous starting at 10:34 a. if she would like to declined. No encouprovided. No additincontinence cares licensed practical rher room to check insulin. LPN-D ther room. Incontinence 1:58 p.m. NA-F and and changed R4's | in and complete peri cares q g], HS [night], and with each g." Id Bladder assessment in the stated 6/24/20, and indicated of bowel and bladder. Id 6/26/20, included, inination." Staff were directed a toileting." The care plan had since 6/26/20, even though the dadecline in urinary ally incontinent and an increase is for toileting and personal I ant Care Sheet included, er [mechanical lift]; does not formation was included to direct for how to attend to R4's Observation on 9/25/20, m. 2 staff members asked R4 lay down. R4 verbally uragement or re-approach was onal attempts to provide occurred. At 11:46 a.m. hurse (LPN)-D brought R4 to blood sugar and administer in brought R4 to the dining er cares were not provided. At di NA-B assisted R4 into bed | F 67 | 77 | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | | E SURVEY PLETED |
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| | | 245090 | B. WING _ | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | 1 031 | 20/2020 |
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| F 677 | since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge without being assist When interviewed of director of nursing (should be assisted hours. The DON staneeds very well. Rowas present review and Bladder assess 6/24/20, noting it in bladder. RN-A revisidentified R4 had not Bladder assessmer significant decline in June of 2020. RN-an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least extended the staneed of the staneed and the staneed at least extended the staneed the staneed at least extended the staneed | ist R4 to lie down or toilet of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. on 9/28/20, at 3:05 p.m. the DON) stated, she thought R4 with incontinent cares every 2 tated she did not know R4's registered nurse (RN)-A who wed R4's most recent Bowel sment, which was dated dicated R4 was continent of rewed R4's medical record and of had an updated Bowel and an condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A re behind on assessments and rk list, "to be caught up." R4 shecked for incontinence and very 2 hours. Dilleting Assistance (policy date "If a client wears an ct, check if soiled or wet and "The facility policy Care date 6/2019) identified "The nodified and updated as the needs of the resident | F 67 | | | |
| F 686 SS=D | | Prevent/Heal Pressure Ulcer 1)(i)(ii) | F 68 | 36 | | 11/2/20 |

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| | | 245090 | B. WING _ | | 09/2 | 28/2020 |
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| F 686 | resident, the facility (i) A resident receive professional stands pressure ulcers and ulcers unless the ir demonstrates that (ii) A resident with professional stands with professional stands promote healing, pr | regrity sure ulcers. orehensive assessment of a must ensure that- ves care, consistent with ards of practice, to prevent d does not develop pressure ndividual's clinical condition they were unavoidable; and oressure ulcers receives ant and services, consistent tandards of practice, to revent infection and prevent eveloping. NT is not met as evidenced tion, interview, and document railed to provide repositioning sidents (R4) reviewed who eloping pressure ulcers. ange Minimum Data Set (MDS) uded severe cognitive diagnosis of dementia. R4 assist for bed mobility and the for transfer. R4 was at risk development, but did not have | F 68 | F686=D. Based on observation, interview, and document review, th facility failed to provide repositionin timely for 1 of 3 residents (R4) reviwho were at risk of developing presulcers. Pleasant Manor staff have the responsibility to provide care to reswho are unable to carry out activitic daily living to promote their health, including assessment during their sand providing care daily. The policy named Repositioning wareviewed and remains appropriate. repositioning plan of care was reviewed and remains free of alterations. All resident's reposition plans of care have been reviewed, discussed at IDT, and repositioning of care remain appropriate. All nursing staff will be educated or | ewed ssure sidents es of stay as R4's ewed n has siskin ning g plans | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | | ` ´COM | E SURVEY PLETED |
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| F 686 | and daily use of AS [blood thinner]. She bladder. Resident rover skin tear on Li otherwise intact. Pr place with toileting hours, pressure red wheelchair and ma cares q [every] AM weekly skin inspection in skin in "Monitor skin integrinspection by nurse order. Pressure redistribut chair." Care plan in R4's care plan furth mobility related to e "Dependent with be staff]. Maxi lift (Hoy transfers. Turn and hours]." Additionall "Alteration in comfo 9/8/20: "Position q2 [as needed] with pi R4's nursing assist "Assist of 2 w/ [with not ambulate." The on how often to ass repositioning. A Hospice Facility \(9/3/20 \) included, "D to bottom." | A [aspirin] and Coumadin is in incontinent of bowel and noted to have scabbed area LE [lower left extremity]. Skin reventative skin measures in and repositioning q [every] 2 distribution cushion to ttress to bed, routine skin [morning] and HS [night], and tions." Ad 6/26/20 included, "Potential tegrity." Staff were directed to, rity daily. Weekly skin is treatment to open areas per distribution mattress to bed. Treatment to wheelchair, terventions updated 9/1/20. The indicated, "Alteration in end of life" with interventions: and mobility: A1-2 [assist of 1-2 feer) [mechanical lift] with reposition Q2H [every 2 feery 2 feery 2 hours] and PRN | F 6 | repositioning policy. DON or designee will perweekly x 4 weeks, month and quarterly thereafter tompliance. Audit results monthly at QAPI meeting recommendations. Completed 11/2/2020 | nly x 3 mor to ensure s will be re | nths, viewed | |

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| F 686 | herself in the whee effectively adjust herself in the whee effectively adjust here members asked R R4 verbally declined offered to recline F declined. No encorprovided. No addit occurred. At 11:46 (LPN)-D brought F sugar and administrepositioned. LPN-room. At 1:55 p.m. NA-B assisted R4 bed using 2 pillows stated, "Oh God, the pain was in her bath when interviewed and NA-B stated the morning cares at 7 not had time to assince getting her unit is terrible." We can't get to her NA-B acknowledge the same position repositioned. R4 shours. When interviewed director of nursing repositioned every The facility policy F5/2013) identified, resident who is improved the same policy F5/2013 identified, resident who is improved the same policy F5/2013 identified, resident who is improved the same policy F5/2013 identified, resident who is improved the same policy F5/2013 identified, resident who is improved the same policy F5/2013 identified, resident who is improved the same policy F5/2013 identified, resident who is improved the same policy F5/2013 identified, resident who is improved the same policy F5/2013 identified in the same policy F5/2013 identified, resident who is improved the same policy F5/2013 identified in the same policy F5/20 | m. R4 was attempting to adjust elchair, but was not able to erself. At 10:34 a.m. 2 staff 4 if she would like to lay down. ed. The 2 staff members R4's wheelchair. R4 verbally uragement or re-approach was ional attempts to reposition a.m. licensed practical nurse R4 to her room to check blood ter insulin. R4 was not D brought R4 to the dining nursing assistant (NA)-F and into bed and positioned her in S. As R4 was laid in bed she hat hurts." R4 specified that the ck. on 9/25/20, at 2:05 p.m. NA-F response to lie down or reposition p at 7:30 a.m. NA-F stated they had sist R4 to lie down or reposition p at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible, we should be." NA-F and red R4 had gone 6.5 hours in in her chair without being should be repositioned every 2 on 9/28/20, at 3:05 p.m. the (DON) stated R4 should be | Fé | 686 | | | |

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| F 686 | every 1 hour (q1 ho Residents who are an every 2 hour (q2 schedule." Facility p Wound Manageme identified "A weekly completed by licens | in a chair should be on an ur) repositioning schedule. in bed should be on at least hour) repositioning policy Skin Assessment and int (revision date 7/2018) skin inspection will be seed staff." | F 686 | 5 | | |
| | CFR(s): 483.25(d)(1) §483.25(d) Accident The facility must en §483.25(d)(1) The r as free of accident §483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN | ts. | F 68 | | | 10/1/20 |
| | review, the facility fassess 3 of 5 resid had fallen, and imply prevent further falls for R1 when she su and fractured her stailed to ensure 2 or reviewed for chokin ordered modified te Findings include: R1's quarterly Minimal R/20/20, included, swith diagnoses includes | ion, interview and document ailed to comprehensively ents (R1, R4, and R3) who ement interventions to . This resulted in actual harm stained 19 falls, broke a finger kull. In addition, the facility f 5 residents (R10 and R5) g risk were served the xture diet. num Data Set (MDS) dated evere cognitive impairment uding TBI (traumatic brain a. R1 required extensive | | F689=G. Based on observation, interview, and document review, the facility failed to comprehensively ass of 5 residents (R1, R4, and R3) who fallen, and implement interventions prevent further falls. This resulted in actual harm for R1 when she sustain falls, broke a finger and fractured he skull. In addition, the facility failed to ensure 2 of 5 residents (R10 and R5 reviewed for choking risk were serve ordered modified texture diet. Pleasant Manor ensures that the residents' environments remain safe as free of accident hazards as poss. The facility identifies each resident a for accidents and develops a plan of | sess 3 b had to n ned 19 er o 5) ed the e and ible. at risk | |

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| | PROVIDER OR SUPPLIER NT MANOR LLC | | | 27 | TREET ADDRESS, CITY, STATE, ZIP CODE 7 BRAND AVENUE ARIBAULT, MN 55021 | | |
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| F 689 | (ADL's) and did not falls with injury sinchad a discharge MIR1's falls Care Area included, "Resident having impaired ba medication use. Refollowing hospitalization in a MVA [Instruction] and increasinvolved in a MVA [Instruction] and increasinvolved in a MVA [Instruction] and increased risk for fa agitation, and daily anticonvulsant, antibenzodiazepine meof bowel and bladder history of falls prior any falls since admito a room closer to Plan to continue to light in reach, and frecommendations.' would be addressed R1's admission Fal 5/19/20, included a falls as identified in there was no analysidentification of intereduce the chance R1's care plan date AEB [as evidenced admission related to | ambulate. R4 had 2 or more e the prior assessment. R1 DS dated 9/16/20. Assessment dated 5/22/20, triggers for falls r/t [related to] lance and daily psychotropic esident has decreased mobility ation for a UTI [urinary tract ased behaviors. Resident was motor vehicle accident] last ered multiple major injuries nited to: skull fractures, TBI, rist fractures." "Resident is at alls r/t cognitive impairment, use of psychotropic, hypertensive, and edications. She is incontinent er. She does not have a to admission and has not had ission. Resident was moved the nurses station for safety. monitor for safety, keep call ollow therapy The CAA indicated falls d in the care plan. Review Evaluation dated check list of risk factors for the 5/22/20 CAA. However, sis of fall risk factors or reventions that may mitigate or | F | 689 | addressing safety issues and imple procedures to prevent accidents ar incidents. The policy related to assessment of have been reviewed and remain appropriate. The policy related to modified textured diets has been reand remain appropriate. R4 and R3's incidents have been reviewed, assessed, and plan of caupdated. R1 has been discharged the facility. All resident's incidents been reviewed, assessed, and plan care updated appropriately. All resident textures plans of care have be reviewed and remain appropriate. Nurses were educated on post fall evaluation process and IDT was earnly incident review and analysis and expectations regarding timely completion. Culinary staff we educated on proper service of mod textured diets Administrator/DON or designee will perform audits weekly x 4 weeks, now x 3 months, and quarterly thereafted ensure compliance. Audit results were viewed monthly at QAPI meeting further recommendations. Completed 10/1/2020 | f falls reviewed re from have n of ident's en lucated nd g ere ified nonthly r to ill be | |

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| F 689 | disturbances." The "Resident will be sa should incident occuse one assist for the Place bed on low proportion of the place bed on the pl | ge 14 goal for R1 was listed as, fe and free from serious injury ur." Staff were directed to, ransfers with a standing lift. Disition. Have fall mats on Leave door open at all times res. Use a tilt-in-space wheel to be visually supervised when wide one on one care, such as wheeling her down the hall. Ary dated 7/1/20 to 9/28/20, llen 17 times on 7/14/20, llen 18/16/20, 8/16/20, 8/19/20, 3/20, 9/14/20 and 9/15/20. In less notes dated 7/29/20 and the had fallen, but these were action Summary. There were or incident reports for the falls tion Summary which were level of a fall from bed onto the level of | F 6 | 89 | | |

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| F 689 | which contributes to diagnosis of unspec consciousness; Ded disturbance." The filisted: proper footw (physical therapy/or lowest position and to be visually super Provide tilt-in-space recline resident who comfort. Staff provide staking her down the hall. "Resident and restlessness are sident's self transito tend to her." The tothe care plan. R1's progress note [certified nursing as [10:00 a.m.] that reschair. Upon entering sitting on the footre recliner was tilting fresident back to sear the self-under the se | resident's fall risks due to cified TBI w/o loss of mentia with behavioral follow-up/intervention section wear, evaluation by PT/OT occupational therapy), bed in soft touch call light. Resident vised when in wheelchair. Wheelchair with the ability to en in chair to provide ore iding 1:1 (one on one) care outside and wheeling her sident with behaviors and often Resident requires 1:1 do to redirect and provide dent is at high fall risk due to eness due to TBI and the also experiences agitation and could be the reason of ferring to get staff's attention ese interventions were added dated 7/29/20, included, "CNA esistant] told writer at 1000 sident had slid forward in her agroom writer found resident st of her recliner and the orward. Three staff assisted at [sic] of the chair." dated 7/31/20, included, "At or resident calling out from her sident on the floor laying next ons were noted to both knees. | F6 | 689 | | |

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| F 689 | dark." Keeping the room is dark was n R1's Incident Revie 8/5/20, identified R: 7/31/20. The reporout of room." No further was documented. Of notifying the nurse anxiety, agitation, rechange in medication restlessness, and a R1's Incident Revie 8/5/20, identified R: on 8/1/20. The form to get out of room." Intervention as the 7/31/20. There was regarding this fall. R1's progress note "Resident found on out. Asked her what going to the floor." It is. R1's progress note included, "Writer note included, "Writer note included, "Writer note included, "It is progress note included, "It is progress note included, "Aid calle included, "Aid calle included, "Aid calle | bathroom light on when the ot added to the care plan. It wand Analysis report dated a was found on the floor on the identified R1 wanted to, "get urther assessment of this fall. However, a new interventions be practitioner of, "frequent estlessness and request a consto decrease anxiety, agitation," was requested. It wand Analysis report dated a had been found on the floor in identified, "Resident wanting. This listed the same 8/5/20 report for the fall on is no assessment completed. It was doing and she said. There was no assessment of dated 8/16/20, at 3:46 p.m. of the physician was then eased anxiety and additional tion was ordered. R1 indicated dated 8/16/20, at 10:28 p.m. d writer into room. Resident and and torso was still in the | F 6 | 89 | | |

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| F 689 | facility." R1's progress note included, "Aid calle sitting on floor with was wanting to leave R1's progress note included, "Resident bed. Resident had slid out of her bed. leave facility and came out of here." R1's progress note "Writer observed remat next to bed this at lowest position. happened and resident here." R1's progress note 2:15 PM writer head Writer found 1" [incomposition of here." R1's progress note 2:15 PM writer head writer found 1" [incomposition of here.] [incomposition | dated 8/16/20, at 10:35 p.m. d nurse in to find resident arms on the bed. Resident re facility." dated 8/16/20, at 10:40 p.m. t was on floor sliding off her just fallen previous to this but Resident was waning [sic] to alling out to staff "someone get dated 8/21/20, included, esident sitting on floor x 3 on a shift. No injuries noted. Bed Asked resident what dent stated, "Trying to get out dated 8/29/20, included, "At red resident yelling from lobby, ent laying on the floor next to eair] yelling "Ow my head." chi x 1.5" abrasion to resident's t was wearing appropriate als in place on W/C, and no . Resident unable to describe ened except that "I fell and hit et towel was applied to und an abrasion on her knee | F 68 | | | |
| | "Writer heard repeat room and found res | dated 8/30/20, included, ated yelling out from resident's sident on the floor next to her west position, call light within | | | | |

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| F 689 | reach, fall mats in president not incontine R1's progress note on right index finge. There was no incide determine when the R1's progress note physician had been index finger. R1's progress note sore right finger." R1's treatment recommonitor right index. However, it did not injury. R1's progress note "Writer heard reside when writer arrived floor next to her been up. Bed was in low place and call light. Even though R1 had there was no compidetermine the reason pattern in time determine why the working to prevent. R1's progress note "Monitor right index bed and part of finger." | dated 8/30/20, noted a bruise r and a scrape on her head. ent report or assessment to ese injuries occurred. dated 8/31/20, included, the updated on bruise to right dated 9/2/20, included, "Ice to ord identified staff were to finger related to a fall. identify which fall caused this dated 9/3/20, included, ent yelling from her room and resident was sitting on the dyelling, "Help me get back rest position with fall mats in in reach." d fallen from bed 13 times, rehensive assessment to on R1 was falling from bed, of day or situation, or to current interventions were not further falls. dated 9/10/20, included, a finger related to a fall." "Nail | F6 | 889 | | | | |

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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL 27 BRAND AVENUE FARIBAULT, MN 55021 | - | 0,20,2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 689 | "Monitor right index "Patients finger cornail bed no redness remains intact at the R1's Incident Revieg 9/15/20, identified In wheelchair on 9/15 cause of R1's fall fr The form identified emergency room for wound. R1's hospital Admist dated 9/15/20, included the formidentified emergency room for wound. R1's hospital Admist dated 9/15/20, included the formidentified emergency room for wound. R1's hospital Admist dated 9/15/20, included the formidentified emergency room for wound. R1's hospital Admist dated 9/15/20, included the formidentified emergency room for the formidentified emergency ro | a finger related to a fall." Intinues to be black around the sor warmth noted to site. Nail is time." Ew and Analysis report dated R1 had fallen from her /20. No assessment of the rom the chair was completed. R1 was sent to the for evaluation due to a head revaluation due to a head related. The finger was found on the seemed to throw hursing station. She has been reset at times. Wanting to go wilts from a CT of head noted red fracture of the left one (skull fracture). R1's summary identified R1 had skull fracture and a fracture of finger which would be splinted the nursing home. The finger age of healing, identifying it the past. The facility identified ht index finger in the the 8/30/20. However, this was physician or x-rayed until | F 6 | 89 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | TE SURVEY MPLETED |
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| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 27 BRAND AVENUE FARIBAULT, MN 55021 | | 72072020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | and trying to stand sit with her one on as other residents residen | up all the time, other than to one, winch was not possible required care too. on 9/24/20, at 1:31 p.m. NA-C in frequently, she would increelf from bed. The only new of was to have the bed in it mats on the floor so when aldn't be injured. NA-C ind a large swollen egg sized and had broken her finger, incent his occurred. on 9/24/20, at 3:07 p.m. R1's y were concerned about R1 increed in the possible of the pos | F6 | 689 | | |
| | director of nursing (a good system for v are trying to improv | on 9/28/20, at 10:10 a.m. the (DON) stated they did not have when someone falls and they e this process. The nurse cident Review and Analysis | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | FIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021 | • | , |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 689 | of these for R1's far sustained on 7/14/29/15/20. The DON assessment had nother falls R1 sustained and really rewhich they were unwas unable to provide termine if there what interventions anxiety/behaviors to frequently. No ass | age 21 e DON was only able to find 4 ills, which were for the falls 20, 7/31/20, 8/1/20, and idid not know why this of been filled out for any of the ained. R1 had behavioral equired one on one attention, hable to provided. The DON ide any assessment to was a pattern to R1's falls, and may assist R1 with her hat led to her falling so essment had been completed to determine interventions that | F 6 | 89 | | |
| | included severe codiagnosis of demedisturbance. R4 remobility and dressi for transfer, toiletin was totally incontincares 1-3 times du R3 had 1 fall witho assessment. R4's fall CAA incluring impaired psychotropic medideclined in both mediagnosis. | ange MDS dated 8/27/20, gnitive impairment with a ntia with behavioral quired extensive assist for bed ng and total staff assistance g, and personal hygiene. R4 ent of bladder and rejected ring the assessment period. ut injury since prior ded, "Resident triggers for falls balance, history of falls, and cation use. Resident has obility and cognitive functions. nrolled in hospice for end of eased risk of falls r/t daily use | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | | ` ´COM | E SURVEY PLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORRECTION CROSS-REFERENCE | PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPE EFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | of hypoglycemic, an narcotic, and psych incontinent of bowe recent fall from bed for safety and keep R4's care plan date related to [blank]. Slowest position. Car Follow PT and OT if function." The most "Ambulate to dining walker] support with 120 ft [feet] x1 [with was added 7/22/20 been made. R4's nursing assist: "Assist of 2 w/ [with not ambulate; fall mat was in place included, "At 7:35 plying on floor next to agitated/anxious ar stand/yell at staff. Fwhen trying to positing so resident as Ax2 [assist of 2 stafall mat was in place lowest position; roo lit." "Resident receis Seroquel [antipsychagitation/anxiety and following hour. Hos of nursing], and emnotified. Writer and about in-facility fame | ntihypertensive, diuretic, notropic medications. She is and bladder. She has had a lide Plan to continue to monitor call light within reach." Ind 6/26/20 indicated, "Fall risk Staff were directed, "Bed in light within reach; fall mat. Instruction for mobility to recent intervention, proom with FWW [front wheel in CGA [contact guard assist] in 1 staff] with FWW support". No additional updates had least Care Sheet included, hower [mechanical lift]; Does not; call light within reach." Indated 8/26/20, at 10:51 p.m. of mourse aide found resident to bed. Resident appeared and continued to try and Resident swinging arms at staff ion Hoyer [mechanical lift] sisted back up into bed with ff]. Call light was within reach; e next to bed; bed was in m was clear of clutter and well wed PRN [as needed] | | 89 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION ING | CON | TE SURVEY MPLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | I SHOULD BE | (X5) COMPLETION DATE |
| F 689 | contact thought it w Emergency contact visit tomorrow." When interviewed oregistered nurse (R incident report or por fall. R4's care plan R4, as she is no lor When interviewed of family member (FM allowed to visit relat concerned about Re would not be able to a visit. No one had possibly visiting to or When interviewed of LPN-D stated R4 ha rolling from bed. The to the bed and mak reach. LPN-D state use the call light an intervention. When interviewed of stated, R4 was to h visits after this fall to The DON stated, th meet after each fall plan, and communic increased family vis communicated to th plan. The facility we plans. R3's admission MD | ould be worth a try; is going to try and stop for a on 9/28/20, at 10:00 a.m. N)-A stated there was no ost fall follow-up report on R4's was incorrect about walking ager able to ambulate. on 9/28/20, at 11:35 a.m. a)-B stated they had not been ted to COVID and was 4's falls. FM-B stated R4 of see them out her window for spoken to them about decrease anxiety. on 9/28/20, at 12:35 p.m. and fallen a couple times, they put a mat on the floor next e sure R4 has her call light in the dR4 would not know how to do was unsure why that was an on 9/28/20, at 3:05 p.m. RN-A ave increased family window of aide in preventing more falls. The interdisciplinary team should and the care sheets and care cate the change, but the | F 6 | 889 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL ⁻ A. BUILDI | TIPLE CONSTRUCTION NG | | OMPLETED |
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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI 27 BRAND AVENUE FARIBAULT, MN 55021 | RRECTION (X5) SHOULD BE COMPLETION | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | COMPLETION |
| F 689 | including a stroke a extensive staff assidaily living (ADL's), of falls prior to admadmission with not delusions or hallucing R3's falls CAA date triggers for falls r/t history of falls, and Resident has had a following hospitalizate weakness. He had increased right side OT at this time with community. Resider that this time with community. Resider that this time with community. Resider that this time with community and hypoglycemic of bowel and bladd vision, and hearing of falls prior to admission whomething on the filmonitor for safety, follow therapy recowould be complete. R3's Fall Review Eincluded a checklis before admission, fuse that can increadeficits, incontinent concerns with balatindings or indication factors would be acceptable. R3's care plan date related to lack of safety. | and dementia. R3 required istance with most activities of was unsteady, had a history hission and had fallen since injury. R3 did not have inations. 2d 8/19/20, included, "Resident having impaired balance, daily antidepressant use. a recent decline in mobility ation for increased overall I a CVA [stroke] and has e weakness. He is in PT and in the goal of returning to the ent is at increased risk of falls insive, psychotropic, diuretic, medications. He is incontinent er. He has impaired cognitive, and Resident does have a history hission and has had one fall here he was reaching for loor. Plan to continue to keep call light in reach, and mmendations. Care planning d. Valuation dated 8/15/20, to frisk factors including fall fall after admission, medication are falls, cognition and sensory ce, confined to chair, and ince. There was no analysis of on on how any of these risk | F6 | 89 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION ING | | TE SURVEY MPLETED |
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| F 689 | and free from falls.' Answer call light profor transfers, follow in reach, proper footitems were in reach R3's progress note included, "Writer was walked in and saw floor. Resident was eating supper. Aid resident up using has Resident states that dropped and he we his wheelchair. Re on the chair that was at the medicine "Pt [patient] was att RN heard some so his wheel chair and saw the resident fa R3's progress note "Writer was called I floor. Resident was and had his hands Resident was sitting up. Resident was atting up. Resident was for all transfers." | 'Staff were directed to, omptly, use a mechanical lift therapy instructions, call light of the state of the s | F 6 | 89 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION IG | COM | E SURVEY MPLETED C |
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| | | 245090 | B. WING _ | | | 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 689 | "Resident was layir Resident was holdi waiving it in the air. right next to him wi Resident states he his room and using out of his way. Resident while do there were no cats assessment of R3's room, even though or delusions at the assessment. When interviewed of LPN-C stated other care plan, no new i any of these falls, any post fall assess The facility had not determine root cau prevent the falls from increased confusion not assessed other which the family definiterdisciplinary teamext day and place that assessment, brown and RN-A states. | dated 9/11/20, included, ag on back on the ground. In handle gripper in hand and Residents wheelchair was the the breaks unlocked. It was chasing the cats out of the handle gripper to get them sident then fell out of bing this." "Resident was told in this facility." There was no as belief there were cats in his R3 had not had hallucinations time of the comprehensive on 9/28/20, at 10:31 a.m. In than what was already in the interventions were added after LPN-C was unable to provide sment for any of these falls. It is assessed each fall to see, nor place interventions to see that to offer psych services, actined. Normally, the im would assess each fall the new interventions based upon ut this had not been done for an 9/28/20, at 11:44 a.m. the ted the facility was not willing | F 68 | 9 | | |
| | resident's who had facilities, "Risk mar | mentation related to any of the fallen as it is part of the nagement." They were unable umentation that R1, R4, or | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION NG | CON | TE SURVEY MPLETED C |
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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 689 | assessed to determ prevent further falls A facility policy titled Management, revis procedure for staff a fall, "staff will more resident's response intervention put in procedure post fall. It is staff will re-evaluate appropriate to continterventions. As not provider will assist not previously identification of the will implement appropriate to reflect the staff will implement approprevent serious injuice updated to reflect R10's quarterly MD cognitively intact willing disease. R10 up assistance with R10's Speech Therincluded a diagnosi | been comprehensively nine interventions that may a from occurring. d, Fall Prevention and sed 2/2020, indicated follow-up after a resident had sustained nitor and document the eto and the effectiveness of place to prevent further falls for 2. If resident continues to fall, ethe situation and whether it's inue or change the current eeded, the resident's medical reconsider possible causes tified. 5. If it is determined and alls may be unavoidable, staff ropriate interventions to any from falls. 6. Care plans will cot fall interventions." S dated 7/14/20, included the diagnoses of diabetes and required supervision and set eating. Tapy evaluation dated 3/26/20, is of pharyngeal phase | F 6 | 89 | | |
| | throat) and oral pha in the mouth). The risk for aspiration of Recommendations consistency, small (chewing), swallow bite/sip, slow pacin between liquids/sol | y swallowing for issues in the ase dysphagia (due to issues evaluation noted R10 was at f food or fluids. were made for puree bites thorough mastication bites before taking another g, single sips, alternate ids. The report indicated uld be required to determine if | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | TE SURVEY MPLETED C |
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| F 689 | R10's nutritional state identified a risk fact diet. No analysis of completed. R10's care plan data nutritional alteration meals; had diet rese [National Dysphaging ground or are minor pieces, they are more and could have requirected to monitor physician as needed swallowing problem. R10's undated nursincluded mechanical meats ground, unfor preference." R10's Oral/Dental Eindicated R10 had sure patty or hard to eat because dentures in. She has the staff had grill. | opriate for diet upgrade. atus CAA dated 4/10/20, tor of a mechanically altered f this risk factor was ted 4/1/20, included, risk for n related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be ed no larger than 1/4 inch bist, with some cohesion] diet juested puree. Staff were , document, and report to the ed for signs and symptoms of | | 9 | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | COMPLETED | |
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| | | 245090 | B. WING | · · · · · · · · · · · · · · · · · · · | 09 | /28/2020 |
| NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC (X4) ID PREFIX TAG F 689 Continued From page 29 nor did anyone bring her dentures. R10's lunch tray ticket included, "Mechanical stexture and to provide ground grilled hamburge potato salad, no raw veggies, beans, shredded lettuce." When interviewed on 9/25/20, at 1:06 p.m. died aide (DA)-A stated residents who require a mechanical soft diet should have been provide with ground meat. R10 coughing is something she normally does while eating. When interviewed on 9/25/20, at 1:12 p.m. coo (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. NAstated 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 | | | | STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 689 | nor did anyone bring R10's lunch tray tick texture and to prove potato salad, no ravelettuce." When interviewed aide (DA)-A stated mechanical soft die with ground meat, she normally does. When interviewed (CK)-A stated, a meground meat, no brown cook is the person correct diet is served. When interviewed stated R10 does counaware R10 did not stated if someone is should go get a nur in the dining room. When interviewed stated she normally today got a regular grilling them. R10 dentures, but forgo have to remind her them. At 1:39 p.m. asked her if she was with the sale of th | ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating. on 9/25/20, at 1:12 p.m. cook echanical soft diet should have read or hard vegetables. The responsible to ensure the ed. on 9/25/20, at 1:21 p.m. NA-Fough at meals, she was ot have dentures in. NA-Fis coughing like that, they rise to assess if no nurse was on 9/25/20, at 1:34 p.m. R10 y gets a ground burger, but whole burger as they were stated she normally wore her to put them in or help her with R10 was coughing and NA-H | | 39 | | |
| | wished for an upgra | ade, but would have to sign a statement. R10 did not have | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | | | COMPLETED | |
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| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | STREET ADDRESS, CITY, STATE, ZIP COD 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| PRÉFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| F 689 | a risk versus benershe given the risks a regular hamburg When interviewed Cook-A stated they who had signed a for a diet upgrade, they can provide it these. R10 should ground meat diet a hamburger. R10's Diet Requisi and dated 3/31/20, speech therapy an Mechanical Soft/G consistency and papureed food if desi When interviewed registered dietician coughing during a the DON, food sent therapy. This had facility should not padiet without risks be and a form signed. When interviewed DON and RN-A state correct diet texts. | fits statement signed nor was of choking when provided with er today. on 9/25/20, at 3:08 p.m. have a file of each resident risk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the sordered and not a regular tion Form provided by Cook-A had been completed by dindicated R10 was to have a round Meat NDD2 diet atient could downgrade to red. on 9/28/20, at 10:21 p.m. the first (RD) stated if a resident were meal it should be reported to vice director and speech not been done for R10. The provide an upgraded texture eing explained to the resident on 9/28/20, at 2:37 p.m. the ated it is important to provide ture for residents with ms. A nurse should be notified | F6 | 89 | | |
| | cognitive impairme | S dated 9/4/20, indicated no ent with diagnoses including, The MDS noted R5 had | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | ····· | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 689 | swallowing medica period. The MDS for oversite, set up whaltered textures. R5's Speech Thera indicated diagnose and oral phase dysindicated R5 had mathematicated the evaluation had dentures that did nowithout dentures, For consistency solids. Advanced. R5 was of materials into the penetration (passa and/or asphyxiation. R5's Care Assessing dated 1/20/20, indimechanically altered completed, but was planning. R5's care plan date risk for nutritional apain front thorax and diet. Staff were direct and report to physical dysphagia when early solved the staff was changed to R5's Progress noted diet was changed to R5's Nutritional Evaluation. | cing during meals or when tions during the assessment curther indicated supervision, en eating and mechanically apy Evaluation dated 1/25/19, so for cerebral infarction (stroke) sphagia. The evaluation further hissing teeth, and at the time of full upper and partial lower of fit. The evaluation indicated as could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx,) in. Then the evaluation the larynx, in. The evaluation indicated as a dieteration related to chronic and diet restriction for NDD3 ected to monitor, document cian for signs or symptoms of | F 6 | 89 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | 09 | C 0/ 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 720,2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | R5's Care guide for and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticked Dysphagia Advance further directed to phamburger on bun, vegetables, backed lettuce, soft ice created buring an observating sat alone at a tawhile she atte her mind whole hamburger with covered the burger. There were various area including nursistopped to see why p.m. R5 was observed to see why p.m. R5 was observed the dining room. When interviewed of stated R5 should have been ground a potato chips or who when interviewed of stated she has occasing light in the results of the dining room. When interviewed of stated she has occasing light in the results of the dining room. When interviewed of stated she has occasing light in the results of the dining room. | estaff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, I care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw I beans, no bacon, shredded am and milk. sion on 9/25/20, at 12:50 p.m. able and was noted to cough leal. R5's plate contained a with a wedge of lettuce that on a bun and potato chips. I staff throughout the dining ling and dietary, but no one of R5 was coughing. At 12:52 wed to be shaking and asked hurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A lave received ground meat, I, soft cooked vegetables. R5 die a bun, the burger should and should not have received on 9/25/20, at 1:10 p.m. R5 desional seizure that are like, | F 6 | 689 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245090 | B. WING | | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, 27 BRAND AVENU FARIBAULT, MN | | 1 03/1 | 20/2020 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | (EACH CO | ER'S PLAN OF CORRECTIO RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 689 | For the noon meal mechanical texture ground hamburger, was the cook's respresident is getting to the cook's respresident is getting to the cook is respresident in the cook is respectively and should ave received the cook who gave her the worder of the cook is respectively and benefit form. Round benefit form. Round benefit form. Round benefit so the cook is respectively and benefits policy resident would be in benefits of necessary opportunity regarding care. The resident would be in the cook is respectively resident would be in the cook is respectively resident would be in the cook is respectively resident would be in the cook is resident. | no bread or hard vegetables. provided on 9/25/20, a should have included, no bun, potato salad and beans. It consibility to make sure a he appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ld get a nurse. R5 should correct diet and did not know wrong diet. on 9/25/20, at 1:40 p.m. on 9/25/20, at 1:40 p.m. or 1:4 | F 6 | 39 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | |
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| | | 245090 | B. WING | | | C 09/28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | 1 00/ | 20/2020 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X (EACH CORRECTIVE ACTION SHOU | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| F 725 SS=F | Dysphagia Mechan Level 1 are allowed foods may be groun no larger than one is should be easy to o Moistened ground of fish. Moist ground with gravy or sauce pureed bread mixes and slurred breads thickness of products. Vegetables vegetables. Vegetables vegetables. Vegeta inch and should be Sufficient Nursing SCFR(s): 483.35(a) (S483.35(a) Sufficient The facility must have the appropriate comprovide nursing and practicable physical well-being of each in resident assessment and considering the diagnoses of the facility must have accordance with the diagnoses of the facility must have appropriate comprovide nursing of each in resident assessment and considering the diagnoses of the facility must have accordance with the diagnoses of the facility must h | nagia Diet indicated NDD2 as ically Altered. All foods on . Meats and other select and or minced into small pieces forth inch. All food items shew. Meats should be or cooked meat, poultry, or or tender meat may be served as Breads products can be as, moistened bread crumbs that are gelled through entire at and to avoid all other bread as should be soft, well-cooked ables should be less than 1/2 easily mashed with a fork. Staff 1)(2) Int Staff. In Staff. I | F 6 | | | 11/2/20 | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | LE CONSTRUCTION | | PLETED |
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| | | 245090 | B. WING | | 09/2 | 28/2020 |
| | PROVIDER OR SUPPLIER | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE TO BRAND AVENUE FARIBAULT, MN 55021 | 1 00/1 | 10,2020 |
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| F 725 | S483.35(a)(2) Exceparagraph (e) of thidesignate a license nurse on each tour This REQUIREMED by: Based on observative review, the facility for staffing to provide for planned needs for R1, R3, R8, R13 ard LPN-A, LPN-D, NANA-A, RN-A, HSK-Members (FM)-A, This had the potentive residents. Findings include: R5's quarterly Minimic included cognitively stroke with paralysist the body and a seizophysical assistance bathing. R5 Care Assessmental 1/20/20, included, activities of daily living and toileting. | ed nurses; and ersonnel, including but not es. Ipt when waived under sesction, the facility must donurse to serve as a charge of duty. In is not met as evidenced stion, interview and document ailed to ensure sufficient or the individualized care of 8 residents (R5, R7, R4, and R12), 12 of 15 staff (LPN-B, L-D, NA-C, NA-J, NA-B, NA-F, LA and NA-C) and 1 of 3 family reviewed for sufficient staffing. The individual service was a charge of sure disorder. R5 required a from staff for toileting and the two worksheet (CAA) dated R5 extensive assistance with ing (ADL) including bathing ated 8/12/20, included, R5 | F 725 | F725=F. Based on observation, in and document review, the facility frensure sufficient staff to provide for individualized care planned needs 8 residents, 12 of 15 staff, and 1 of family members, reviewed for sufficient residents. Pleasant Manor has the responsib provide services by sufficient number promote resident rights and dignity. The policy in regards to completing Facility Assessment has been reviewed remains appropriate. The facility completed a facility assessment to assess and identify appropriate staffing needs for the elevel of care and provide guidance future staffing needs for the appropriate of care. Daily staffing assign will be signed off by Administrator Director of Nursing daily. Education will be completed with Ill through QAPI and with facility staff through an all-staff meeting regard executed facility assessment and creview of staffing. Administrator or designee will perfaudits weekly x 4 weeks, monthly in the control of the second of the seco | ailed to r the for 8 of f 3 cient ct all 42 ility to pers to dewed current for priate ments or DT ling daily corm | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIP | LE CONSTRUCTION | COM | (X3) DATE SURVEY COMPLETED | |
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| F 725 | licensed practical in not getting the time toileting, bathing are enough staff. R5 d When interviewed a stated, "This facility over an hour to get R5 stated it takes at the bathroom, and, Sunday and a show would rather I just to less time and effort because they say to the time and effort because they say to the time and to wait for have enough staff to Sometimes they had onot have enough when interviewed a licensed practical in complained of not go basis. This was up doing the best they R5's Grievance/Co not receive a bath of stated, "R5's showed evening due to time did not get done due to the stated of the stated of the stated of the dollar to the stated of the s | on 9/24/20, at 12:23 p.m. urse (LPN)-A stated, R5 was ly care she needed with ad hygiene as there was not id complain about this. on 9/24/20, at 2: 20 p.m. R5 is very short staffed. I wait an answer to my call light." I long time to get help to go to "I should have a bath every wer every Wednesday. The aid ake a shower because it takes in Sometime, I get neither there are not enough aids on." to R5. on 9/24/20, at 3:22 p.m. a NA)-D stated R5 required hing and toileting, but often assistance as they do not so get to everyone timely. In the second of the s | | months, and quarterly there compliance. Audit results we monthly at QAPI meetings is recommendations. Completed: 11/2/2020 | vill be reviewed | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 725 | had a lot to do and time to get in the be another shower that that we never got of that we never got of the call light 166 time wait time was over 41.5% of the time. R7's admission ME moderate cognitive of a stroke. R7 was required assistance transfer on and off R7's ADL (activities Rehab Care Asses dated 9/25/20, included in mobility, of bowel and bladd toileting upon required assistance dependent assist, opersonal hygiene s occasionally incontwith toilet use." | or until 6 p.m. After 6 we still ended up not having enough ath R5 wanted. There was also at was supposed to get done one." ds dated July to September a shower on 7/19 but not and then not again until ed a bath on 9/13/20, but not Il light log from 9/1/20 (6:53 24 p.m.), indicated, R5 used nes. Of the 166 instances, the 20 minutes on 69 occasions or OS dated 7/28/20, included impairment with a diagnosis a occasionally incontinent and be by one staff person to of the toilet. Sof daily living)/Functional sment Area Worksheet (CAA) uded, R7 has had a recent was occasionally incontinent er, and needed assistance for | F 72 | 5 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245090 | B. WING | | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | | 27 | REET ADDRESS, CITY, STATE, ZIP CODE BRAND AVENUE RIBAULT, MN 55021 | <u> 091.</u> | 20/2020 |
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| F 725 | week she found R7 when she started h was not enough started hygiene needs in a When Interviewed was lying in bed. R facility is very bad. there seems to be a facility. Call lights chour. I push the call bathroom and no owet myself. I feel he chair and embarrast cleaned up and chair and embarrast cleaned assisted R7 aft secondary to waiting time for the call light that there have been beginning of the sh soiled and need assinght shift is custom one licensed praction one licensed praction urse (RN) for the a facility. | NA)-C reported the previous solled halfway up her back er shift. NA-C reported there aft to meet R7's toileting and | F 7 | 25 | | | |
| | LPN-D stated there | was insufficient staff to meet so of each resident. The | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | IPLE CONSTRUCTION IG | COM | PLETED |
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| F 725 | of this. R7's call light response 9/22/20, at 3:51 a.m. showed the call light the seven day periodinitiated, 11 (or 21.9 15 minutes to receive a response receive receive a response receive receiv | f and residents is low because onse time logs dated from n. to 9/28/20, 9:25 a.m. In twas engaged 51 times over od. Of the 51 call light alerts 5%) of these alerts took over ve a response. Seven (or s took longer than 20 minutes ise. Inimum Data Set (MDS) dated moderate cognitive impairment uding diabetes, dementia and ed extensive assistance with assistance with personal of on a toileting program and icontinent of urine (less than 7 sessment period). Care Area Assessment (CAA) ted, "Resident triggers for e r/t [related to] need for | F 72 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | IPLE CONSTRUCTION NG | CON | COMPLETED | |
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| F 725 | "Resident triggers toilet use and bladd declined in both me She has recently elife cares. Residen aid in keeping skin current toileting pla [every] AM [mornin incontinent episode R4's only Bowel ar medical record was R4 was continent of R4's care plan date "Alteration with elir to, "Assist of 1 with not been updated s8/27/20, MDS note incontinence to total in assistance need hygiene. R4's nursing assist "Assist of 2 w/ Hoy ambulate." No informursing assistants toileting needs. During continuous starting at 10:34 a. if she would like to declined. No encouprovided. No additincontinence cares licensed practical rher room to check | for urinary incontinence r/t der incontinence. Resident has obility and cognitive function. nrolled in hospice for end of t uses incontinence products to dry. Plan to continue to with an and complete peri cares q ig], HS [night], and with each | | 25 | | |

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| | | 245090 | B. WING | | 09 | C / 28/2020 | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 725 | 1:58 p.m. NA-F and and changed R4's without being assisted hours. The DON stoneds very well. Rowas present review and Bladder assess 6/24/20, noting it in bladder. RN-A reviidentified R4 had not Bladder assessmer significant decline in June of 2020. RN-an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least every well. In the property was present review and Bladder assessmer significant decline in June of 2020. RN-an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least every was the wait to should have should have been of changed at least every was the wait to should have wait to should have been of the property of the | In NA-B assisted R4 into bed visibly wet brief. In 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or toilet of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. In 9/28/20, at 3:05 p.m. the (DON) stated, she thought R4 with incontinent cares every 2 tated she did not know R4's egistered nurse (RN)-A who wed R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and of the had an updated Bowel and int, even though she had an condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4 shecked for incontinence and very 2 hours. In 9/1/20 - 9/29/20 revealed th 20 times. Of the 20 time was over 10 minutes on a 40 minutes on one occasion, | | 725 | | | |

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| F 725 | 8/20/20, included, swith diagnoses inclinjury) and dementiassistance with mo (ADL's) and did not falls with injury since had a discharge MIR1's care plan date AEB [as evidenced admission related to secondary to TBI and disturbances." The "Resident will be sashould incident occur "Provide one on on and wheeling her during her disturbances." The facility provided from 7/21/20 thorour 1 had fallen in the frame. 7/14/20, 8/11/20, 8/11/20, 8/11/20, 8/11/20, 8/11/20, 8/11/20, 8/11/20, 8/11/20, 8/11/20, 8/11/20 and 9/15/20 Hospital discharge indicated R1 was transfer 9/15/20 after sustain agitation. Summary fractured skull and R1's progress notes revealed: | mum Data Set (MDS) dated revere cognitive impairment uding TBI (traumatic brain a. R1 required extensive st activities of daily living ambulate. R1 had 2 or more e the prior assessment. R1 DS dated 9/16/20. d 9/2/20, included, "Fall risk by] multiple falls since to lack of safety awareness and Dementia with behavioral goal for R1 was listed as, afe and free from serious injury ur." Staff were directed to, e care, such as taking outside bown the hall." d a running list of R1's falls and 9/24/20, which indicated facility 17 times in that time ba1/20, 8/16/20, 8/5/20, 8/6/20, 12/20, 8/16/20, 9/3/20, | F 72 | 5 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
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| | | 245090 | B. WING | | | 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | DE | |
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| F 725 | included R1 had at several times after Facility transferred started to yell out a and back. R1 report neck and back. R1 wheelchair. Facility ratio as the | dated 9/16/20, at 5:35 p.m. tempted to crawl out of bed returning from the hospital. R1 to her wheelchair, R1 then nd reported of pain in neck ted to facility of pain in her started to stand up from her initiated a 2 to 1 staff to R1 determined R1 was not safe. contacted and consulted and to be sent back to the dian was informed of the dated, 9/16/20, at 6:24 p.m. cansferred back the hospital. And to the police and transport arse called the hospital to returning to them due to dian dated and R1 was extremely agitated ever at staff, attempted to a floor, yelling and hollering and, R1 was extremely agitated ever attempted and R1 we towards staff. Facility called emergency department (ED) on per physician's orders. Son 9/24/20, at 1:00 p.m. NA-B mes when R1 required one on they only had one or two staff to desidents, so this was not | F 72 | 5 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
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| F 725 | emergency room s would not take R1 they did not have e enough. When interviewed stated R1 required time to prevent her not have the time to NA-D stated she w when arriving for he wet," in her incontinuted there was not R1 and keep her sa attention. When interviewed the DON stated due to could not be met at | e fell a lot. on 9/24/20, at 2:56 p.m. the ocial worker stated the facility back to the facility because nough help to watch her well on 9/24/20, at 3:22 p.m. NA-D a significant amount of staff from falling and they just did o stay with her all the time. orked the day shift and often er shift would find R1, "sopping | F 725 | | | |
| | 8/15/20, revealed Fimpairment. R3 red staff physical assis diagnosis included swallowing concerr mouth when eating mouth/cheeks or red | nimum data set (MDS), dated R3 had moderate cognitive quired supervision and one tance for eating. R1's a stroke. R3 had the following his: loss of liquids/solids from or drinking, holding food in esidual food in mouth aftering during meals or when | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | COMPLETED | |
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| F 725 | staff, "The resident with adequate eatir all meals in the din supervision-not to ris provided." When interviewed stated she worked "understaffed." NA be provided mornir especially if they reassistance with me required individual not eat too quickly get enough fluid. Nover 40 minutes to in the dining room. When interviewed stated, R3 required make sure he ate that staff were available around the room, when interviewed stated, there were assistance in the dining room to figure out how to entire time due to continue assistance. During observation wheeled self into the wheel chair back a | tions. It updated 9/24/20, directed aneeds a calm, quiet meal timeing time. The resident requires ing room r/t [related to] close receive meals until supervision on 9/24/20, at 12:56 p.m. NA-A day shift and considered it, and reported residents waited to a grares prior to breakfast, equired two staff and considered lift. NA-A stated, R3 assistance for cueing him to or take too big of a bite and to A-A noted R3 often had to wait eat until they had enough staff | | 25 | | |

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| | | 245090 | B. WING | | | 28/2020 |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 725 | stated there is never room to feed every | age 46 on 9/25/20, at 1:21 p.m. NA-F er enough staff in the dining one. "On a good day, we are es to assist all the residents." | F 72 | 5 | | |
| | was cognitively intal Parkinson's disease assistance of 2 state and one person physical R8's care plan, last staff, "Alteration in Parkinson's" and, "needed for hygiene When interviewed on the parkinson's and the parkinson and t | on 9/24/20, at 12:23 p.m. | | | | |
| | the morning and ne afternoon. LPN-A ne her call light on but When interviewed a stated, "We barely more independent residents who requively when interviewed a stated there was nowhen she needed i with stiffness and don her own when her states and don her states are states and don her own when her states and don her own when her states are states and states are states and states are states and states are states and states are states are states and states are sta | as independent with cares in eeded more assistance in the loted R8 might not even turn holler out for staff. on 9/24/20, at 12:56 p.m. NA-A touch base," with R8 as she is and staff need to help with ired more assistance. on 9/28/20, at 10:37 a.m. R8 of enough staff to help her t. R8 stated she has problems lecreased ability to do things er Parkinson's medication was ff tell her they have a half hour | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | PLE CONSTRUCTION G | ` ´cor | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---|--|-------------------------------|----------------------------|--|
| | | 245090 | B. WING | | | C / 28/2020 | |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021 | | | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 725 | but it is often over to they do not have end time. R8 stated should be the bathroom, she will be the bathroom, she will be to get on on her back to hurt an unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and dated August 2020 Carbidopa-Levodop Parkinson's disease stiffness, tremors, so control) five times of 4:00 p.m., 7:30 p.m. noted as being adneach opportunity, be not noted. When interviewed the LPN-D stated getting her medicated R8's call light log, of included, R13 active two incidents, the reand 40 minutes. On time was between a incident, the responsibility of the proposition of the p | time her medication is due, hat. R8 stated staff tell her nough staff to get it to her on e does not get enough help to often has to wait 20-40 or off the toilet. This causes dishe gets even more still and herself even more. ministration record (MAR), included an order for toa (a medication for treating e symptoms such as muscle spasms, and poor muscle daily; 5:55 a.m., 10:00 a.m., a. and 11:30 p.m. R8 was ministered the medications at the time administered was an enter the medications on the R8 reported concerns with the sines on time in the evening. Mated 9/8/20 through 9/25/20, atted her call light 12 times. On the esponse time was between 30 and 50 minutes. On one has time was over 100. S dated 9/18/20, included the a diagnosis of multiple uired two staff for toileting and | F 72 | 5 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
|--|--|--|---------------------|---|------------------------------|----------------------------|
| | | 245090 | B. WING _ | | | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 725 | risk for skin breakd assistance. The cacall light in reach at When interviewed stated R13 was totacares. Sometimes breakfast as they dher up before break up, but is agreeable Often R13 would be were able to attend When interviewed stated when comin they would find R13 often the only staff competent to use the get R13 up, and duin bed at supper tinthey just didn't have her up. When interviewed stated she is incommedical condition, periods of time to be addition, she ofte because there is not addition, she ofte because there is not This was upsetting R13's call light logs reviewed. R13's call light logs reviewed. R13's call sight logs reviewed. R13's call light logs reviewed. R13's call light logs reviewed. R13's call between 40 and 50 between 50 and 60 betwe | own and required staff are plan indicated to keep the and answer promptly. on 9/24/20, at 1:31 p.m. NA-C ally dependent on staff for R13 had to stay in bed for idn't have enough staff to get a when they need her to be. e, "saturated" by the time they to her after breakfast. on 9/24/20, at 3:22 p.m. NA-D g on for the afternoon shift a soaked in urine. NA-D was on afternoons who was ne mechanical lift needed to be to this, often R13 had to stay ne. This would upset R13, but a enough help to always get on 9/28/20, at 11:05 a.m. R13 tinent of urine due to her she often has to wait extended be changed in order to be dry. en is unable to get out of bed oft enough staff to help her up. | F 72 | 5 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | | | |
|--|---|---|---|----|--|-------|----------------------------|
| | | 245090 | B. WING | | | | 28/2020 |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 725 | R12 had moderate was on hospice ser care. R12's diagnos disease, asthma/ch disease or chronic failure. R12's medication a report (MAR/TAR), staff, "Connect 02 bedtime." and "Oxy cannula while at remarked as complete 9/17/20. The MAR/has bipap on every cpap placement. Plevery hour overnight completed on 9/4/2 "Bipap-Nurse must sleeping and at night completed the night On 9/24/20, at 3:45 family had concerns was, "slower," and residents. On 9/25/20 at 10:38 R12, (FM)-A stated through video. R12 and oxygen nasal cassist with respirate | S dated 8/14/20, included, cognitive impairment. R12 vices and required oxygen ses included coronary artery pronic obstructive pulmonary lung disease and respiratory and treatment administration dated August 2020, directed 1.5 L [liters]/min [minute] at 1.5 L [liters]/min [minute] at 1.5 L [min per nasal st and at night. This was not led on the night of 9/4/20 and TAR directed "Ensure resident overnight, every night shift for ease ensure Cpap is in place of 1.5 L (min per nasal st and 9/17/20. and put on use daily when het." This was not marked as to 6 9/4/20 and 9/17/20. 1. p.m. LPN-B stated, R12's and a sabout staffing. LPN-B R12 "needier," than other 2. a.m. a family member of the she monitored R12's care wore a bipap mask at night cannula during the day to bry and breathing issues. FM-A | F 7 | 25 | DEFICIENCY) | | |
| | not applied, or not a amounts of time, no 3:20 a.m. to 3:50 a. | R12's bipap or oxygen was applied properly for significant oting recent example between m.; 5:00 a.m. to 7:10 a.m., :17 a.m. on 9/24/20. FM-A | | | | | |

| | OF DEFICIENCIES DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION ING | - (X | (3) DATE SURVEY COMPLETED |
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| | | 245090 | B. WING | | _ | C 09/28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA 27 BRAND AVENUE FARIBAULT, MN 55021 | ATE, ZIP CODE | 0012012020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECTIV CROSS-REFERENCEI | IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY) | |
| F 725 | reported, during the the facility to alert set the interview, R12 when she was not eneeded, like she was R12 was deteriorated physically and was the oxygen. FM-As she noted no came movement detected 11:34 p.m. and 4:00 required frequent in was on properly. FI she felt like a burde had informed the disconcerns and there improvement. R12's call light log, included, R12 active Eleven of those we minutes. Six were a minutes. | ese instances, she would call staff, without response. During noted she did not feel well getting the oxygen she as in a "daze". FM-A reported ing both cognitively and more confused when not on stated, on 9/18/20 to 9/19/20 era activity, indicating no d, in R12's room between 9 p.m. FM-A noted R12 nonitoring to ensure her bipap M-A reported R12 had told her en to staff. FM-A reported she irector of nursing of her e was no resolution or dated 9/1/20 to 9/29/20, atted the call light 66 times. The answered between 20 to 30 answered between 30 to 40 answered between 40 and 50 answered in over 60 minutes on 9/24/20, at 12:23 p.m. If were not enough staff to care a explained there were e aide on west side of the care were not getting the timely care mely toileting, bathing and oad was stressful and if burnout and turnover. LPN-A cussed concerns with DON and there had been no eported she helped the with cares when she was able completing treatments and | | 725 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | NG | | | ATE SURVEY DMPLETED C |
|--|--|--|--|-----|--|---------|----------------------------|
| | | 245090 | B. WING | | | 0 | 9/28/2020 |
| PLEASANT MANOR LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 725 Continued From page 51 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. NAreported she was pulled away from her nursing assistant duties to help with electronic medical appointments and wound rounds. There was no 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 | | | STREET ADDRESS, CITY, STATE, ZIP COD 27 BRAND AVENUE FARIBAULT, MN 55021 | | | | |
| PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFI TAG | (EA | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 725 | medication pass for there was an overar getting the timely as hygiene. When interviewed or reported she was presistant duties to lappointments and sufficient nursing structure peri-cares for residents were not evening cares where chart a resident reference had not been offered bathed, when they been reported to be with no changes. When interviewed of stated she worked times when she worked times resident to the was nothing to when interviewed to the there was nothing to when interviewed or residents. Nurses to personal cares for saddition to their registers. | r residents. LPN-A reported II concern with resident not esistance with bathing and on 9/24/20, at 1:31 p.m. NA-C ulled away from her nursing nelp with electronic medical wound rounds. There was not eaff to provide oral care and ents. The nurses were too duties to assist. Most of the | | 25 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 245090 | B. WING | | 09 | C / 28/2020 | |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE | |
| F 725 | staffing agency, the they do not have er their work. LPN-B management and with when interviewed of HSK-A stated nursi "burned out," becautime to meet reside. When interviewed administrator, assist RN-A were interviewed administrator, assist RN-A were interviewed. Typically, the assistant per 10 reswere residents who wait times, particula "The staff have manoticed "a lot of state administrator noted dynamics and cultus staffing concerns. The staff there was a but felt there was too many staff and reported there was too many staff and reported there was census was down. The facility staffing staff, "Our facility provide care ad ser accordance with restart and the staff with the skills a provide care ad ser accordance with restart was the staff with the skills a provide care ad ser accordance with restart was the staff with the skills a provide care ad ser accordance with restart was the staff with the skills a provide care ad ser accordance with restart was the staff with the skills a provide care ad ser accordance with restart was the staff with the skills a provide care ad ser accordance with restart was the staff with the skills a provide care ad ser accordance with restart was the staff with the skills a provide care ad ser accordance with restart was the staff with the skills a provide care ad ser accordance with restart was the staff | by are reluctant to return as anough time to complete all of thad reported this concern to was told they had enough staff. In 9/25/20, at 11:12 p.m. Ing assistance seem to be, use they do not have enough nt needs. In 9/28/20, at 3:36 p.m. the stant administrator, DON and wed together. There was no to determine the specific eet resident care planned here should be 1 nursing sidents. DON stated there is complained about call light arly at night time. RN-A stated, de it seem so drastic" but | F 7 | 25 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | ` IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | ` ' | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING _ | | | C 28/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/2 | -0/-0-0 | |
| DI 5404 | NT MANOR I I O | | | 27 BRAND AVENUE | | | |
| PLEASA | NT MANOR LLC | | | FARIBAULT, MN 55021 | | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | N | (X5) | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | | COMPLÉTION DATE | |
| F 725 | Continued From pa | age 53 | F 72 | 5 | | | |
| | | ect care staff are determined | | | | | |
| | | residents based on each | | | | | |
| | resident's plan of c | | | | | | |
| F 805 | | eet Individual Needs | F 80 | 5 | | 11/2/20 | |
| SS=D | CFR(s): 483.60(d)(| 3) | | | | | |
| | | | | | | | |
| | §483.60(d) Food ar | | | | | | |
| | Each resident rece | ives and the facility provides- | | | | | |
| | 8483 60(d)(3) Food | d prepared in a form designed | | | | | |
| | to meet individual r | | | | | | |
| | | NT is not met as evidenced | | | | | |
| | by: | | | | | | |
| | | tion, interview, and document | | F805=D. Based on observation, | | | |
| | | ailed to prepare food in | | interview, and document review, th | ıe | | |
| | | sidents needs for 2 of 3 | | facility failed to prepare food in | | | |
| | | R10) reviewed who required | | accordance with residents needs f | | | |
| | modified texture die | ets. | | 3 residents reviewed and required modified texture diets. | | | |
| | Findings include: | | | Pleasant Manor residents have the | e riaht to | | |
| | | | | receive food prepared in a form de | | | |
| | | S dated 7/14/20, included | | to meet their individual needs. Ple | | | |
| | | ith diagnoses of diabetes and | | Manor staff have a responsibility to | | | |
| | | required supervision and set | | monitor and ensure that the reside | | | |
| | up assistance with | eating. | | receive food prepared in a form to | meet | | |
| | P10's Speech Ther | rapy evaluation dated 3/26/20, | | their individual needs. The associated policies related to | convina | | |
| | | is of pharyngeal phase | | appropriate diet texture have been | | | |
| | | y swallowing for issues in the | | reviewed and remain appropriate. | | | |
| | | ase dysphagia (due to issues | | All residents diet textures were rev | viewed | | |
| | in the mouth). The | evaluation noted R10 was at | | and remain appropriate. All physic | | | |
| | risk for aspiration o | | | orders match culinary meal card s | | | |
| | | were made for puree | | Education was provided to all staff | | | |
| | | bites thorough mastication | | regarding serving appropriate mod | ittied | | |
| | | bites before taking another | | diet textures during meal time. | | | |
| | | g, single sips, alternate lids. The report indicated | | Culinary Director/Dietitian or desig perform audits weekly x 4 weeks, | | | |
| | | uld be required to determine if | | x 3 months, and quarterly thereafte | | | |
| | Tartion analysis wo | ala 20 regulied to determine il | | A 5 months, and quartony therealth | J. 10 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | |
|--|---|---|--------------------|-----|--|-------|----------------------------|
| | | 245090 | B. WING | | | | 28/2020 |
| | PROVIDER OR SUPPLIER | | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 7 BRAND AVENUE ARIBAULT, MN 55021 | 1 00/ | 20/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 805 | R10's nutritional state identified a risk fact diet. No analysis of completed. R10's care plan dat nutritional alteration meals; had diet res [National Dysphagia ground or are minor pieces, they are more and could have requirected to monitor, physician as needes swallowing problem. R10's undated nurs included mechanical meats ground, ufor preference." R10's Oral/Dental Eindicated R10 had in During observation was observed to be 12:47 p.m. it was not hamburger patty or | opriate for diet upgrade. atus CAA dated 4/10/20, for of a mechanically altered of this risk factor was ated 4/1/20, included, risk for a related to coughing during atrictions which included NDD2 a Diet, level 2- meats are to be and no larger than 1/4 inch bist, with some cohesion] diet at uested puree. Staff were a document, and report to the d for signs and symptoms of | | 805 | ensure compliance. Audit results verviewed monthly at QAPI meeting further recommendations. Completed 11/2/2020 | | |
| | hard to eat because dentures in. She has the staff had gril desired one. R10 c | | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | TIPLE CONSTRUCTION NG | ` ' | MPLETED |
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| | | 245090 | B. WING _ | | 05 | C 9/ 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 27 BRAND AVENUE FARIBAULT, MN 55021 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 805 | texture and to provipotato salad, no ravilettuce." When interviewed aide (DA)-A stated mechanical soft die with ground meat, she normally does with ground meat, no brook is the person correct diet is served. When interviewed a stated R10 does con unaware R10 did not stated if someone is should go get a nur in the dining room. When interviewed a stated she normally today got a regular grilling them. R10 dentures, but forgo have to remind her them. At 1:39 p.m. asked her if she was with the salad and the stated resident's die stated resident's dietaled. | g her dentures. ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded on 9/25/20, at 1:06 p.m. dietary residents who require a st should have been provided R10 coughing is something while eating. on 9/25/20, at 1:12 p.m. cook echanical soft diet should have ead or hard vegetables. The responsible to ensure the responsible to ensure the ed. on 9/25/20, at 1:21 p.m. NA-F ough at meals, she was of have dentures in. NA-F is coughing like that, they rese to assess if no nurse was on 9/25/20, at 1:34 p.m. R10 or gets a ground burger, but whole burger as they were stated she normally wore her them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H | F 80 | 05 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | TE SURVEY MPLETED |
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| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZII 27 BRAND AVENUE FARIBAULT, MN 55021 | | 720/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 805 | a risk versus benefit she given the risks a regular hamburger. When interviewed of Cook-A stated they who had signed a rifor a diet upgrade, at they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisiti and dated 3/31/20, speech therapy and Mechanical Soft/Groonsistency and papureed food if desir. When interviewed or registered dietician coughing during a rithe DON, food servitherapy. This had rifacility should not prodiet without risks be and a form signed. When interviewed of DON and RN-A state the correct diet text swallowing problem if a resident is coughing a resident is coughing the swallowing problem if a resident is coughing if a resident is coughing in the swallowing problem if a resident is coughing a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem if a resident is coughing in the swallowing problem in the swallowing problem is a resident in the swallowing problem in the | of choking when provided with or today. On 9/25/20, at 3:08 p.m. have a file of each resident lisk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the sordered and not a regular did indicated R10 was to have a found Meat NDD2 diet tient could downgrade to ed. On 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to ice director and speech not been done for R10. The rovide an upgraded texture eing explained to the resident were find the indicated R10 was to have a not been done for R10. The rovide an upgraded texture eing explained to the resident on 9/28/20, at 2:37 p.m. the ted it is important to provide ure for residents with us. A nurse should be notified | F8 | 305 | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION IG | COM | E SURVEY MPLETED |
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| | | 245090 | B. WING _ | | | 28/2020 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| | swallowing medicate period. The MDS for oversite, set up whe altered textures. R5's Speech Thera indicated diagnoses and oral phase dysindicated R5 had more that did nowithout dentures, R consistency solids a Advanced. R5 was of materials into the penetration (passagand/or asphyxiation R5's Care Assessmedated 1/20/20, indicated 1/20/ | ions during meals or when ions during the assessment urther indicated supervision, en eating and mechanically by Evaluation dated 1/25/19, so of cerebral infarction (stroke) phagia. The evaluation further issing teeth, and at the time of full upper and partial lower of fit. The evaluation indicated 5 could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx, in ent Area Worksheet (CAA) eated R5 required a didet. There was no analysis a noted to proceed to care | F 80 | 05 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | TE SURVEY MPLETED |
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| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 27 BRAND AVENUE FARIBAULT, MN 55021 | | 720/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 805 | R5's Care guide for and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticked Dysphagia Advance further directed to phamburger on bun, vegetables, backed lettuce, soft ice created buring an observat R5 sat alone at a tawhile she ate her myhole hamburger were various area including nurs stopped to see why p.m. R5 was observed the dining room. When interviewed of stated R5 should have been ground a potato chips or who when interviewed of stated she has occasing likely and has not when interviewed of stated she has occasing likely and has not when interviewed of stated she has occasing likely and has not when interviewed of cook-A stated the formal stated she has occasing likely and has not when interviewed of cook-A stated the formal stated she has occasing likely and has not when interviewed of cook-A stated the formal stated she has occasing likely and has not when interviewed of cook-A stated the formal stated she has occasing likely and has not when interviewed of cook-A stated the formal stated she has occasing likely and has not when interviewed of cook-A stated the formal stated she has occasing likely and has not when interviewed of cook-A stated the formal stated she has occasing likely and has not stated she has occasing | estaff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, I care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw I beans, no bacon, shredded am and milk. sion on 9/25/20, at 12:50 p.m. able and was noted to cough leal. R5's plate contained a with a wedge of lettuce that on a bun and potato chips. I staff throughout the dining ling and dietary, but no one of R5 was coughing. At 12:52 wed to be shaking and asked hurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A lave received ground meat, I, soft cooked vegetables. R5 die a bun, the burger should and should not have received on 9/25/20, at 1:10 p.m. R5 desional seizure that are like, | F8 | 305 | | |

| | FOF DEFICIENCIES DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | IPLE CONSTRUCTION NG | COM | TE SURVEY MPLETED |
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| | | 245090 | B. WING _ | | | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 805 | have ground meat, For the noon meal mechanical texture ground hamburger was the cook's respected to the cook's respected to the cook's respected to the cook's respected to the cook of th | no bread or hard vegetables. provided on 9/25/20, a should have included, no bun, potato salad and beans. It ponsibility to make sure a she appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ald get a nurse. R5 should correct diet and did not know wrong diet. on 9/25/20, at 1:40 p.m. orted both dietary and nursing trays. on 9/25/20, at 3:06 p.m. RN-B is ok to be provided an a risk and benefit form had desident should be given the sician if there is no signed risk at a signed form. p.m. Cook-A- stated R5 ed the ordered diet, but did sponsible for providing the I of Care/Interventions, Risk of dated 9/11, identified a nformed of the risk and ary care and given the ng their decision in the plan of would be approached 2-3 ant continued to refuse, buld be made on the Refusal of Risk and Benefits and | F 80 | 05 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | CON | TE SURVEY MPLETED |
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| | | 245090 | B. WING | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP (27 BRAND AVENUE FARIBAULT, MN 55021 | • | 120/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 805 | Dysphagia Mechan Level 1 are allowed foods may be grour no larger than one if should be easy to compose Moistened ground of fish. Moist ground with gravy or sauce pureed bread mixes and slurred breads thickness of product products. Vegetable vegetables. Vegeta | ge 60 nagia Diet indicated NDD2 as ically Altered. All foods on . Meats and other select and or minced into small pieces forth inch. All food items hew. Meats should be or cooked meat, poultry, or or tender meat may be served. Breads products can be an instened bread crumbs that are gelled through entire at and to avoid all other bread es should be less than 1/2 easily mashed with a fork. | F8 | 05 | | |



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

Kamala Fishe Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: kamala.fiske-downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 13, 2020

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

Re: State Nursing Home Licensing Orders

Event ID: 2XHN11

Dear Administrator:

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

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Pleasant Manor LLC October 13, 2020 Page 2

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

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

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

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

Karen Aldinger, Unit Supervisor Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900

Email: karen.aldinger@state.mn.us

Office: (651) 201-3794 Mobile: (320) 249-2805

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program

Minnesota Department of Health

Kamala Fishe Downing

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

(X6) DATE

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 00568 | B. WING | | | 8/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | *****ATTE | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and mumber and mum | nether a violation has been | | | | |
| | that was violated du corrected. | uring the initial inspection was | | | | |
| | that may result from orders provided tha the Department with | hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance. | | | | |
| | survey was conduct with State Licensure NOT in compliance Please indicate in y correction that you | TS: 2) and 9/28/20, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed. | | | | |

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 10/30/20

TITLE

Minnesota Department of Health

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | STATE, ZIP CODE | | | |
| PLEASA | NT MANOR LLC | 27 BRANI FARIBAUI | DAVENUE LT, MN 5502 | 21 | | | |
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| 2 000 | Continued From pa | ge 1 | 2 000 | | | | |
| | SUBSTANTIATED N H5090056C: MN RU H5090057C MN RU Rule 4658.0525 Su H5090059C MN RU | laints were found to be with a licensing order issued: ule 4658.0520 Subp. 1 and MN le 4658.0510 Subp. 1 and MN le 4658.0510 Subp. 1; MN le 4658.0510 Subp. 1; MN le 6 B.; and MN Rule | | | | | |
| | unsubstantiated: H | laints were found to be 5090055C and H5090058C ed in ePOC and therefore a uired at the bottom of the first | | | | | |
| 2 800 | MN Rule 4658.0510 Staffing requiremen |) Subp. 1 Nursing Personnel; ats | 2 800 | | | 11/2/20 | |
| | home must have or number of qualified registered nurses, I nursing assistants t residents at all nurs in all buildings if mo | requirements. A nursing a duty at all times a sufficient nursing personnel, including icensed practical nurses, and o meet the needs of the les' stations, on all floors, and one than one building is ides relief duty, weekends, sements. | | | | | |
| | by: Based on observati review, the facility fa staffing to provide for planned needs for 8 R1, R3, R8, R13 an | ent is not met as evidenced on, interview and document ailed to ensure sufficient or the individualized care 3 of 8 residents (R5, R7, R4, ad R12), 12 of 15 staff (LPN-B, -D, NA-C, NA-J, NA-B, NA-F, | | Area Acknowledged | | | |

Minnesota Department of Health

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 00568 | B. WING | | I | 2 <mark>8/2020</mark> |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
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| 2 800 | Continued From pa | ge 2 | 2 800 | | | |
| | members (FM)-A, | A and NA-C) and 1 of 3 family reviewed for sufficient staffing. ial to affect all 42 current | | | | |
| | Findings include: | | | | | |
| | included cognitively stroke with paralysis the body and a seiz physical assistance bathing. | num Data Set dated 9/4/20, intact with diagnoses of s or weakness on one side of ture disorder. R5 required from staff for toileting and | | | | |
| | 1/20/20, included, | nt Worksheet (CAA) dated R5 extensive assistance with ing (ADL) including bathing | | | | |
| | needed assistance shower/bath with or | ated 8/12/20, included, R5 with toilet use and ne assist twice a week on esday evenings with skin | | | | |
| | licensed practical n not getting the time toileting, bathing an | on 9/24/20, at 12:23 p.m. urse (LPN)-A stated, R5 was ly care she needed with d hygiene as there was not id complain about this. | | | | |
| | stated, "This facility over an hour to get R5 stated it takes a the bathroom, and, Sunday and a show would rather I just to less time and effort | on 9/24/20, at 2: 20 p.m. R5 is very short staffed. I wait an answer to my call light." long time to get help to go to "I should have a bath every ver every Wednesday. The aid ake a shower because it takes. Sometime, I get neither pers are not enough aids on " | | | | |

Minnesota Department of Health

STATE FORM 6899 2XHN11 If continuation sheet 3 of 49

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | 27 BRANI FARIBAUI | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETE DATE |
| 2 800 | nursing assistant (Nassistance with bat she had to wait for have enough staff the Sometimes they had on not have enough when interviewed of licensed practical in complained of not go basis. This was up doing the best they receive a bath of stated, "R5's showed evening due to time did not get done due bath requires two a only two on the flood had a lot to do and time to get in the bath another shower that that we never got described again until 8/17/20, 8/24//20. R5 received again until 9/21/20. Review of R5's cal p.m.) to 9/29/20 (2: the call light 166 times. | to R5. on 9/24/20, at 3:22 p.m. a NA)-D stated R5 required hing and toileting, but often assistance as they do not o get to everyone timely. ve to skip R5's bath as they n time. on 9/24/20, at 3:45 p.m. a urse (LPN)-B stated, R5 getting her shower on a regular setting to her, but they were could. oncern Report included, R5 did or shower on 7/22/20. NA-I er did not get done on Sunday e." NA-J stated, "R5's shower e to running out of time. Her ids which [NA-I] and I were the r until 6 p.m. After 6 we still ended up not having enough ath R5 wanted. There was also t was supposed to get done one." ds dated July to September a shower on 7/19 but not and then not again until ed a bath on 9/13/20, but not | 2 800 | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 1 00:2 | |
| PLEASANT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| moderate cognitive of a stroke. R7 was required assistance transfer on and off of the R7's ADL (activities Rehab Care Assess dated 9/25/20, included in mobility, wo for bowel and bladded to | S dated 7/28/20, included impairment with a diagnosis occasionally incontinent and by one staff person to of the toilet. of daily living)/Functional sment Area Worksheet (CAA) ded, R7 has had a recent was occasionally incontinent er, and needed assistance for st. d 7/29/20, included, R7 for, "Bathing with max to ressing with max assist, et-up with minimal assist, nent, and requires assistance on 9/24/20, at 1:31 p.m. a IA)-C reported the previous soiled halfway up her back er shift. NA-C reported there ff to meet R7's toileting and | 2 800 | | | |

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Minnesota Department of Health

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 03/2 | 0/2020 |
| PLEASA | NT MANOR LLC | 27 BRAND | | 14 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 800 | nursing assistant (N wait for assistance her incontinent. Thi Most residents wait time to receive an a has assisted R7 aft secondary to waitin time for the call light that there have been beginning of the sh soiled and need as night shift is custom one licensed praction nurse (RN) for the afacility. When interviewed a LPN-D stated there the individual needs morale among staff of this. R7's call light responsationally assistance, and the seven day periodinitiated, 11 (or 21.5 minutes to receive a responsationally and dementians assistance with mo (ADL's) and did not the seven did not the call injury) and dementians assistance with mo (ADL's) and did not the seven did not the call injury and did not the call injury) and dementians is the call injury and dementians is the call injury) and dementians is the call injury and did not t | on 9/25/20, at 2:35 p.m. NA)-D stated R7's often has to to the bathroom which makes is was always upsetting to R7. For an extended period of answer to their call light. NA-D er R7 was incontinent in the for a prolonged period of it to be answered. NA-D stated in, "Too many times," at the iff when several residents are insistance. NA-D stated the introduced in the intr | 2 800 | BEI MENOTY | | |

Minnesota Department of Health

STATE FORM 6899 2XHN11 If continuation sheet 6 of 49

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | 00568 | B. WING | | 09/2 | 28/2020 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| PLEASANT MANOR LLC 27 BRANE FARIBAU | | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 2 800 | R1's care plan date AEB [as evidenced admission related to secondary to TBI and disturbances." The "Resident will be satisfied one on on and wheeling her downward to the frame. The facility provide from 7/21/20 thorous R1 had fallen in the frame. The facility provide from 7/21/20, 8/11/20, 8/12/20, 8/8/16/20, 8/19/20, 8/9/14/20 and 9/15/20 Hospital discharge indicated R1 was tree 9/15/20 after sustain agitation. Summary fractured skull and R1's progress note revealed: -9/16/20, at 4:36 p. from the hospital. R1's progress note included R1 had attiseveral times after Facility transferred started to yell out a and back. R1 report neck and back. R1 wheelchair. Facility ratio as the facility of R1's physician was | ed 9/2/20, included, "Fall risk by] multiple falls since o lack of safety awareness and Dementia with behavioral e goal for R1 was listed as, afe and free from serious injury bur." Staff were directed to, e care, such as taking outside own the hall." d a running list of R1's falls ugh 9/24/20, which indicated e facility 17 times in that time 31/20, 8/1/20, 8/5/20, 8/6/20, 8/1/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 9/3/20, 0. summary dated 9/16/20, cansferred to the hospital on ining a fall related to increased of details R1 incurred a | 2 800 | | | |

Minnesota Department of Health

STATE FORM 6899 2XHN11 If continuation sheet 7 of 49

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | A. BUILDING: | | | | | |
| | | 00568 | B. WING | | 09/2 | , 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| DI EASANT MANOPII C | | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | transfer situation. R1's progress note included, R1 was tr full report was give teams. The floor nuinform that R1 was safety concerns. R1's progress note included, R1 was n marked behaviors: put herself onto the louder than her usu and 1:1, 2:2, 3:3 we remained aggressive 911 to send R1 to effor further evaluation. When interviewed a stated there were to one attention, but the cover a unit of 30 repossible. When interviewed a stated they did not all the time and she would not take R1 in the simulation. | dian was informed of the dated, 9/16/20, at 6:24 p.m. ansferred back the hospital. A n to the police and transport arse called the hospital to returning to them due to d dated 9/16/20, at 6:28 p.m. oted to have continued swore at staff, attempted to a floor, yelling and hollering al, R1 was extremely agitated are attempted and R1 we towards staff. Facility called amergency department (ED) on per physician's orders. on 9/24/20, at 1:00 p.m. NA-B mes when R1 required one on ney only had one or two staff to assidents, so this was not on 9/24/20, at 1:31 p.m. NA-C have enough help to watch R1 | 2 800 | | | |
| | stated R1 required time to prevent her | on 9/24/20, at 3:22 p.m. NA-D a significant amount of staff from falling and they just did o stay with her all the time. | | | | |

Minnesota Department of Health

STATE FORM 6899 2XHN11 If continuation sheet 8 of 49

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---------------------|---|--------|--------------------------|
| | | 00568 | B. WING | | 09/2 | 28/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| PLEASA | PLEASANT MANOR LLC 27 BRAN FARIBAL | | | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 800 | Continued From pa | ge 8 | 2 800 | | | |
| | NA-D stated she wo | orked the day shift and often er shift would find R1, "sopping | | | | |
| | stated there was no | on 9/24/20, at 3:45 p.m. LPN-B ot enough staffing to supervise afe as she required individual | | | | |
| | DON stated due to could not be met at | on 9/28/20, at 10:10 a.m. the limited staffing R1's needs the facility, therefore R1 could fter her last admission to the | | | | |
| | 8/15/20, revealed R impairment. R3 req staff physical assist diagnosis included swallowing concern mouth when eating mouth/cheeks or re | nimum data set (MDS), dated as had moderate cognitive uired supervision and one cance for eating. R1's a stroke. R3 had the following as: loss of liquids/solids from or drinking, holding food in sidual food in mouth after ag during meals or when iions. | | | | |
| | staff, "The resident with adequate eatin all meals in the dini | updated 9/24/20, directed needs a calm, quiet meal time g time. The resident requires ng room r/t [related to] close eceive meals until supervision | | | | |
| | stated she worked of "understaffed." NA- be provided mornin especially if they red assistance with med | on 9/24/20, at 12:56 p.m. NA-A day shift and considered it, -A reported residents waited to g cares prior to breakfast, quired two staff and chanical lift. NA-A stated, R3 assistance for cueing him to | | | | |

Minnesota Department of Health

STATE FORM 6899 2XHN11 If continuation sheet 9 of 49

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|----------------------------|--|--|---|---|-----------|-------------------------------|--|
| | | 00568 | B. WING | | I | C 28/2020 | |
| | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | | | |
| PLEASANT MANOR LLC FARIBAU | | | LT, MN 5502 | 21 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE | |
| 2 800 | Continued From pa | ge 9 | 2 800 | | | | |
| | not eat too quickly of get enough fluid. Not over 40 minutes to in the dining room to when interviewed of stated, R3 required make sure he ate the | or take too big of a bite and to A-A noted R3 often had to wait eat until they had enough staff | | | | | |
| | | raiting for his plate of food. | | | | | |
| | stated, there were s assistance in the di to figure out how to entire time due to c | on 9/24/20, at 3:45 p.m. LPN-B several residents that required ning room and it was difficult feed R3. R3 required help the hoking precautions and a the entire meal time. | | | | | |
| | wheeled self into th wheel chair back ar | on 9/25/20, at 12:21 p.m. R3 e dining room. R3 rolled his nd forth at the table, looking al was brought to him at 12:41 | | | | | |
| | stated there is never room to feed everyout lucky to have 2 aide R8's admission MD was cognitively inta Parkinson's disease assistance of 2 staff | on 9/25/20, at 1:21 p.m. NA-F or enough staff in the dining one. "On a good day, we are es to assist all the residents." S, dated 8/10/20, included, R8 ct with a diagnosis of e. R8 required physical of for transfers and supervision ysical assistance for toileting. | | | | | |
| | staff, "Alteration in e | revised 8/24/20, directed elimination r/t [related to] Assist of 1 with toileting as | | | | | |
| | When interviewed of | on 9/24/20. at 12:23 p.m. | | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--------------------------|--|--------|--------------------------|
| | | 00568 | B. WING | | 1 | 2 <mark>8/2020</mark> |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502° | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 800 | the morning and ne afternoon. LPN-A n her call light on but When interviewed of stated, "We barely more independent a residents who requively more independent a residents who requively more independent a residents who requively more interviewed of stated there was not when she needed it with stiffness and don her own when he late. R8 stated staff on each side of the but it is often over they do not have entime. R8 stated she the bathroom, she of minutes to get on oher back to hurt and unable to care for her back to | as independent with cares in reded more assistance in the oted R8 might not even turn holler out for staff. on 9/24/20, at 12:56 p.m. NA-A touch base," with R8 as she is and staff need to help with ired more assistance. on 9/28/20, at 10:37 a.m. R8 of enough staff to help her to R8 stated she has problems ecreased ability to do things ar Parkinson's medication was feel her they have a half hour time her medication is due, that. R8 stated staff tell her nough staff to get it to her on a does not get enough help to often has to wait 20-40 or off the toilet. This causes dishe gets even more still and erself even more. ministration record (MAR), included an order for a (a medication for treating a symptoms such as muscle spasms, and poor muscle laily; 5:55 a.m., 10:00 a.m., and 11:30 p.m. R8 was ninistered the medications at ut the time administered was | 2 800 | | | |
| | time. LPN-D stated | anted her medications on I R8 reported concerns with ions on time in the evening. | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--|------------------------|--|-------------------------------|--------------------------|
| | | | A. BUILDING. | | | . |
| | | 00568 | B. WING | | 1 | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASANT MANOR LLC 27 BRAND FARIBAUL | | | DAVENUE LT, MN 5502 | 11 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | Continued From pa | ge 11 | 2 800 | | | |
| | included, R13 active two incidents, the real and 40 minutes. Or time was between 4 | lated 9/8/20 through 9/25/20, ated her call light 12 times. On esponse time was between 30 in two incidents the response 40 and 50 minutes. On one use time was over 100 | | | | |
| | 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. | | | | | |
| | stated R13 was total cares. Sometimes I breakfast as they di her up before breakf up, but is agreeable Often R13 would be | on 9/24/20, at 1:31 p.m. NA-C ally dependent on staff for R13 had to stay in bed for idn't have enough staff to get afast. R13 would prefer to get when they need her to be. e, "saturated" by the time they to her after breakfast. | | | | |
| | stated when coming they would find R13 often the only staff competent to use the get R13 up, and due in bed at supper time | on 9/24/20, at 3:22 p.m. NA-D g on for the afternoon shift a soaked in urine. NA-D was on afternoons who was ne mechanical lift needed to e to this, often R13 had to stay ne. This would upset R13, but e enough help to always get | | | | |
| | | on 9/28/20, at 11:05 a.m. R13 inent of urine due to her | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | OATE SURVEY OMPLETED | |
|--|---|---|---------------------|--|------|--------------------------|--|
| | | | | | | | |
| | | 00568 | B. WING | | 09/2 | 8/2020 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | |
| PLEASA | NT MANOR LLC | | AVENUE | | | | |
| | OLIMANA DV. OTA | | _T, MN 5502 | | ON. | 0.4=> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| 2 800 | Continued From pa | ge 12 | 2 800 | | | | |
| | medical condition, speriods of time to b | she often has to wait extended e changed in order to be dry. en is unable to get out of bed of enough staff to help her up. | | | | | |
| | reviewed. R13's cal 10 and 20 minutes 20 and 30 minutes 30 and 40 minutes between 40 and 50 between 50 and 60 | for 9/8/20 to 9/25/20, was Il light response was between on 30 occurrences, between on 15 occurrences, between on seven occurrences, minutes on five occurrences, minutes on 5 occurrences s 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. | | | | | | |
| | report (MAR/TAR), staff, "Connect 02 1 bedtime." and "Oxy cannula while at resmarked as complet 9/17/20. The MAR/has bipap on every cpap placement. Plevery hour overnigh completed on 9/4/2 "Bipap-Nurse must sleeping and at night completed the night." | put on use daily when ht." This was not marked as t of 9/4/20 and 9/17/20. | | | | | |
| | | p.m. LPN-B stated, R12's and s about staffing. LPN-B R12 | | | | | |

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|-------------------------|--|-------------------------------|--------------------------|
| | | 00568 | B. WING | | C 09/28/2020 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | • | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 800 | residents. On 9/25/20 at 10:38 R12, (FM)-A stated through video. R12 and oxygen nasal cassist with respirate would notice times not applied, or not a amounts of time, no 3:20 a.m. to 3:50 a. and 10:10 p.m. to 1 reported, during the the facility to alert sithe interview, R12 right when she was not gneeded, like she was R12 was deteriorated physically and was the oxygen. FM-A sishe noted no came movement detected 11:34 p.m. and 4:08 required frequent minutes and there improvement. R12's call light log, included, R12 active Eleven of those were minutes. Six were a minutes. | ge 13 Ineedier," than other Ineedier," than | 2 800 | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--------------------------------------|--|-------------------------------|--------------------------|
| | | 00568 | B. WING | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | 27 BRAND | DRESS, CITY, S' D AVENUE LT, MN 5502 | TATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 2 800 | LPN-A stated there for residents. LPN-sometimes only one center. Residents withey needed with tire hygiene. The workle contributing to staff stated, she had distant administrator are resolution. LPN-A renursing assistants what was busy with a medication pass for there was an overal getting the timely as hygiene. When interviewed or reported she was passistant duties to he | ge 14 were not enough staff to care A explained there were a aide on west side of the care were not getting the timely care mely toileting, bathing and bad was stressful and burnout and turnover. LPN-A cussed concerns with DON and there had been no eported she helped the with cares when she was able completing treatments and a residents. LPN-A reported II concern with resident not esistance with bathing and on 9/24/20, at 1:31 p.m. NA-C ulled away from her nursing nelp with electronic medical wound rounds. There was not | 2 800 | | | |
| | sufficient nursing st peri-cares for reside busy with their own time baths and sho residents were not evening cares when chart a resident refe had not been offere bathed, when they been reported to be with no changes. When interviewed of stated she worked times when she wo building. Resident extended periods of hour. They just cou | raff to provide oral care and ents. The nurses were too duties to assist. Most of the wers were missed and assisted with morning and they preferred. Staff would used a bath, when the resident ed, or chart a resident was were not bathed. This had oth the DON and administrator on 9/24/20, at 3:22 p.m. NA-D the night shift and there were uld be the only nurse aid in the call lights were on for f time- sometimes over an uld not get to them timely. At the too of the complain of cold food. | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION |) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (AZ) MOLIN LI | E CONSTRUCTION | (X3) DATE | |
|---|---|---------------------|--|-----------|--------------------------|
| AND I BUT OF COTALECTION | IDENTIFICATION NUMBER. | A BLUI DING: | | ` ´COMPI | |
| | | A. DOILDING. | | _ | |
| | | B. WING | | C | |
| | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, S | TATE, ZIP CODE | | |
| DI FACANT MANOR LLC | 27 BRAND | AVENUE | | | |
| PLEASANT MANOR LLC | FARIBAUL | T, MN 5502 | 1 | | |
| PREFIX (EACH DEFICIENCY MUS | ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 800 Continued From page 1 | 15 | 2 800 | | | |
| "Short staffing is a daily been reported to the ad there was nothing they of When interviewed on 9/ stated there was one or residents. Nurses were personal cares for 5 resuddition to their regular were not able to make so were completed. When staffing agency, they are they do not have enough their work. LPN-B had management and was to When interviewed on 9/ HSK-A stated nursing as "burned out," because to time to meet resident now When interviewed on 9/ administrator, assistant RN-A were interviewed facility assessment to destaffing needs to meet residents who comed wait times, particularly assistant per 10 resident were residents who come wait times, particularly as "The staff have made it noticed "a lot of standing administrator noted she dynamics and culture of staffing concerns. The assistant per 10 improper and chipping in within he she felt there was an adbut felt the communication. | diministrator but was told could do about it. /24/20, at 3:45 p.m. LPN-B recorded to provide sidents each shift in duties. Sometimes, they sure resident treatments in staff come from a recorded this concern to told they had enough staff. /25/20, at 11:12 p.m. assistance seem to be, they do not have enough eeds. /28/20, at 3:36 p.m. the administrator, DON and together. There was no determine the specific resident care planned should be 1 nursing ints. DON stated there implained about call light at night time. RN-A stated, a seem so drastic but ing around." The ewas working on team shange in response to administrator reported she oving the staffing situation increabilities. DON reported dequate number of staff tion was poor. DON tuation where there was swork got done. RN-A | 2 800 | | | |

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | PLEASANT MANOR LLC 27 BRAN | | | | | |
| | | _T, MN 5502 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY) | D BE | (X5) COMPLETE DATE |
| 2 800 | Continued From pa | ge 16 | 2 800 | | | |
| | staff, "Our facility prestaff with the skills a provide care ad ser accordance with resuscessment." and "requirements of directly the needs of the resident's plan of care administrator, DON adequate policy and sufficient staffing be population so reside and timely assistant repositioning, pressussistance. The fact these policies and president care to ensure and services facility could report the quality assurance (QAPI) committee fensure ongoing correctly. | HOD OF CORRECTION: The or designee could ensure that d programs are developed for ased on the resident ents received safe, adequate ce with toileting, bathing, sure ulcer care, and eating cility could educate staff on perform routine evaluations of sure residents are receiving or adequate staffing. The the findings of these audits to be performance improvement for further recommendations to | | | | |
| 2 830 | | O Subp. 1 Adequate and re; General | 2 830 | | | 11/2/20 |
| | 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 | | | | | |

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Minnesota Department of Health

| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 00568 | D. WING | | 09/2 | 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| PLEASA | PLEASANT MANOR LLC 27 BRAN | | | 14 | | |
| (V4) ID | SLIMMARY STA | TEMENT OF DEFICIENCIES | LT, MN 5502 | PROVIDER'S PLAN OF CORRECTION | - N | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ge 17 | 2 830 | | | |
| | written order from t | he attending physician that the in bed or the resident | | | | |
| | 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. | | | area acknowledged | | |
| | Findings include: | | | | | |
| | 8/20/20, included, s with diagnoses inclinity) and dementi assistance with mo (ADL's) and did not | num Data Set (MDS) dated severe cognitive impairment uding TBI (traumatic brain a. R1 required extensive st activities of daily living ambulate. R4 had 2 or more e the prior assessment. R1 DS dated 9/16/20. | | | | |
| | included, "Resident having impaired ba medication use. Refollowing hospitalization infection] and incresinvolved in a MVA [In November and sufficients in the control of th | a Assessment dated 5/22/20, triggers for falls r/t [related to] lance and daily psychotropic esident has decreased mobility ation for a UTI [urinary tract ased behaviors. Resident was motor vehicle accident] last ered multiple major injuries nited to: skull fractures, TBI, | | | | |

Minnesota Department of Health

Minnesota Department of Health

| MILLIFOC | ota Department of He | alui | 1 | | | |
|-------------------|--|--|----------------|--------------------------------|-----------|------------------|
| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
| | | | | | 0 | ` |
| | | 00568 | B. WING | | | 8/2020 |
| | | 00300 | | | 03/2 | 0/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| DI E 4 0 4 | NT MANOR LLO | 27 BRANI | AVENUE | | | |
| PLEASA | NT MANOR LLC | FARIBAUI | LT, MN 5502 | 21 | | |
| (V4) ID | QUIMMADV QTA | TEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF CORRECTION |)N | (VE) |
| (X4) ID PREFIX | | / MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROI | PRIATE | DATE |
| | | | | DEFICIENCY) | | |
| 2 830 | Continued From pa | ne 18 | 2 830 | | | |
| 2 000 | Continued From pa | gc 10 | 2 000 | | | |
| | | rist fractures." "Resident is at | | | | |
| | increased risk for fa | alls r/t cognitive impairment, | | | | |
| | | use of psychotropic, | | | | |
| | anticonvulsant, anti | | | | | |
| | • | dications. She is incontinent | | | | |
| | | er. She does not have a | | | | |
| | | to admission and has not had | | | | |
| | | ission. 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 f | | | | | |
| | | The CAA indicated falls | | | | |
| | would be addressed | d in the care plan. | | | | |
| | 541 1 1 5 5 5 1 | | | | | |
| | | Review Evaluation dated | | | | |
| | | check list of risk factors for | | | | |
| | | the 5/22/20 CAA. However, | | | | |
| | | sis of fall risk factors or | | | | |
| | | rventions that may mitigate or | | | | |
| | reduce the chance | of RT falling. | | | | |
| | D1's sere plen dete | d 0/2/20 included "Fall rick | | | | |
| | | d 9/2/20, included, "Fall risk | | | | |
| | | by] multiple falls since | | | | |
| | | o lack of safety awareness nd Dementia with behavioral | | | | |
| | , | | | | | |
| | | goal for R1 was listed as, afe and free from serious injury | | | | |
| | | ur." Staff were directed to, | | | | |
| | | ransfers with a standing lift. | | | | |
| | | osition. Have fall mats on | | | | |
| | • | Leave door open at all times | | | | |
| | | res. Use a tilt-in-space wheel | | | | |
| | | o be visually supervised when | | | | |
| | | vide one on one care, such as | | | | |
| | | wheeling her down the hall. | | | | |
| | taking outside and | wheeling her down the hall. | | | | |
| | R1's Action Summa | ary dated 7/1/20 to 9/28/20, | | | | |
| | | illen 17 times on 7/14/20, | | | | |
| | | /20, 8/6/20, 8/11/20, 8/12/20, | | | | |
| | | 16/20, 8/16/20, 8/19/20, | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|---|-----------|--------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | |
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| | | 00568 | B. WING | | 09/2 | 28/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| DIEACA | NT MANOR LLC | 27 BRAND | AVENUE | | | |
| PLEASA | NT MANOR LLC | FARIBAUI | _T, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ge 19 | 2 830 | | | |
| | addition, R1's programmers addition, R1's programmers and some of the notion progress notes of identified on the Action dated 8/11/20, 8/12 9/14/20. Twelve of progress notes as a mat next to the bed 8/5/20, 8/6/20, 8/16 times, 8/29/20, 8/30 identified from a wr 9/15/20. 1 fall from was no documenta circumstances of the notion of the second sec | 13/20, 9/14/20 and 9/15/20. In the sess notes dated 7/29/20 and the had fallen, but these were Action Summary. There were or incident reports for the falls tion Summary which were 1/20 (2 falls), 8/19/20, or the falls were identified in the being a fall from bed onto the 1. These were on 7/31/20, 1/20 - three times, 8/21/20 - 3 1/20, and 9/3/20. 2 falls were neel chair on 8/29/20 and 1/20/20, are falls that occurred on 1/20, 8/12/20, 8/19/20 or | | | | |
| | included, R1 was for Incident Analysis in resident's room and floor." "Resident would which contributes to diagnosis of unspectonsciousness; Dedisturbance." The flisted: proper footwood (physical therapy/or lowest position and to be visually super Provide tilt-in-space recline resident who comfort. Staff provident staking her down the hall. "Resident who can be composed to the staking her down the hall." The staken heard yelling attention to staff and floor." | w and Analysis dated 7/20/20, bund on the floor on 7/14/20. cluded, "Staff was walking by d saw resident lying on the ith lack of safety awareness or resident's fall risks due to cified TBI w/o loss of mentia with behavioral follow-up/intervention section year, evaluation by PT/OT ccupational therapy), bed in soft touch call light. Resident vised when in wheelchair. It wheelchair with the ability to en in chair to provide ore iding 1:1 (one on one) care outside and wheeling her sident with behaviors and often. Resident requires 1:1 d to redirect and provide dent is at high fall risk due to | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | | 7. BOILDING | | С | |
| | | 00568 | B. WING | | | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | dementia. Resider and restlessness a resident's self trans to tend to her." The to the care plan. R1's progress note [certified nursing as [10:00 a.m.] that re chair. Upon enterir sitting on the footre recliner was tilting fresident back to se R1's progress note 8:40 PM writer hea room and found resto her bed." Abrasi There was no asse Interventions adderesident's bedroom and will keep bathredark." Keeping the room is dark was no R1's Incident Revie 8/5/20, identified R 7/31/20. The reporout of room." No fuwas documented. of notifying the nurs anxiety, agitation, rechange in medicatir restlessness, and a R1's Incident Revie R1's Incident Revier R1's Incident R1's Inciden | eness due to TBI and at also experiences agitation and could be the reason of aferring to get staff's attention ese interventions were added dated 7/29/20, included, "CNA asistant] told writer at 1000 sident had slid forward in her ag room writer found resident at of her recliner and the forward. Three staff assisted at [sic] of the chair." dated 7/31/20, included, "At ard resident calling out from her sident on the floor laying next ons were noted to both knees. | 2 830 | | | |
| | on 8/1/20. The form | n had been found on the floor identified, "Resident wanting This listed the same | | | | |

Minnesota Department of Health

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Minnesota Department of Health

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | | A. BUILDING: | | C | |
| | | 00568 | B. WING | | | 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASANT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | intervention as the 7/31/20. There was regarding this fall. R1's progress note "Resident found on out. Asked her what going to the floor." this. R1's progress note included, "Writer not medication aide] at was on the floor." It bed. The note indication of the in | 8/5/20 report for the fall on a no assessment completed dated 8/6/20, included, floor by bed on knees. yelling the she was doing and she said. There was no assessment of dated 8/16/20, at 3:46 p.m. of tified by TMA [trained 1500 [3:00 p.m.] that resident R1 was sitting on floor mat by cated the physician was then eased anxiety and additional ion was ordered. R1 indicated dated 8/16/20, at 10:28 p.m. diviter into room. Resident and and torso was still in the confused and wanted to leave dated 8/16/20, at 10:35 p.m. diviter into find resident arms on the bed. Resident arms on the bed. Resident arms on floor sliding off her just fallen previous to this but Resident was waning [sic] to alling out to staff "someone get | 2 830 | | | |
| | "Writer observed re | dated 8/21/20, included, sident sitting on floor x 3 on shift. No injuries noted. Bed | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | | | | | С | |
| | | 00568 | B. WING | | 09/2 | 28/2020 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| PLEASA | PLEASANT MANOR LLC 27 BRAN FARIBAU | | | 21 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETE DATE | |
| 2 830 | Continued From pa | ge 22 | 2 830 | | | | |
| | at lowest position. Asked resident what happened and resident stated, "Trying to get out of here." | | | | | | |
| | 2:15 PM writer hear Writer found reside her W/C [wheel chaw Writer found 1" [inc forehead. Residen footwear, foot peda incontinence noted to writer what happen my head." Cool we | dated 8/29/20, included, "At rd resident yelling from lobby. nt laying on the floor next to air] yelling "Ow my head." h] x 1.5" abrasion to resident's t was wearing appropriate Is in place on W/C, and no. Resident unable to describe ened except that "I fell and hit it towel was applied to and an abrasion on her knee | | | | | |
| | 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." | | | | | | |
| | on right index finge There was no incide | dated 8/30/20, noted a bruise r and a scrape on her head. ent report or assessment to ese injuries occurred. | | | | | |
| | | dated 8/31/20, included, the updated on bruise to right | | | | | |
| | R1's progress note sore right finger." | dated 9/2/20, included, "Ice to | | | | | |
| | monitor right index | ord identified staff were to finger related to a fall. identify which fall caused this | | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---|--|-------------------------------|--------------------------|
| | | 00568 | B. WING | | l l | C 28/2020 |
| | PROVIDER OR SUPPLIER | 27 BRAN | DRESS, CITY, S D AVENUE LT, MN 5502 | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| 2 830 | R1's progress note "Writer heard reside when writer arrived floor next to her bed up. Bed was in low place and call light Even though R1 had there was no comp determine the rease any pattern in time determine why the working to prevent R1's progress note "Monitor right index bed and part of fing R1's progress note "Monitor right index "Patients finger con nail bed no redness remains intact at th R1's Incident Revie 9/15/20, identified F wheelchair on 9/15, cause of R1's fall fr The form identified emergency room for wound. R1's hospital Admis | dated 9/3/20, included, ent yelling from her room and resident was sitting on the d yelling, "Help me get back est position with fall mats in in reach." d fallen from bed 13 times, rehensive assessment to on R1 was falling from bed, of day or situation, or to current interventions were not further falls. dated 9/10/20, included, finger related to a fall." "Nail ler appears black." dated 9/13/20, identified to, finger related to a fall." atinues to be black around the grow warmth noted to site. Nail is time." w and Analysis report dated R1 had fallen from her (20. No assessment of the om the chair was completed. R1 was sent to the or evaluation due to a head | 2 830 | DEFICIENCY | | |
| | floor in bedroom an herself on floor at n agitated/verbally up upstairs." The resi | ided, "Patient was found on id then seemed to throw ursing station. She has been iset at times. Wanting to go ults from a CT of head noted ced fracture of the left | | | | |

Minnesota Department of Health

| STATEME | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|---|-------------------------|---|-------------------|--------------------------|
| | | | A. BUILDING. | | | |
| | | 00568 | B. WING | | 1 | , 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | O AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | posterial parietal be hospital discharge sustained a closed her right hand 2nd the before returning to fracture was in a stand happened in the an injury to R1's rigprogress notes on an ot assessed by a phospitalized on 9/15. When interviewed on the stated R1 had faller wheel chair, she was and required one of fall. NA-B stated the on ones with R1. In interventions that he and trying to stand sit with her one on as other residents of the low position and R1 did this she wouremembered R1 had area on her forehead but did not know where we will be sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the | one (skull fracture). R1's summary identified R1 had skull fracture and a fracture of finger which would be splinted the nursing home. The finger age of healing, identifying it to e past. The facility identified the index finger in the the 8/30/20. However, this was obysician or x-rayed until 5/20. On 9/24/20, at 1:00 p.m. NA-B in from bed a lot and from her as constantly trying to stand up in one attention or she would ey did not have time to do one lA-B did not know of any elped R1 with the agitation up all the time, other than to one, winch was not possible equired care too. On 9/24/20, at 1:31 p.m. NA-C in frequently, she would herself from bed. The only new of was to have the bed in a mats on the floor so when aldn't be injured. NA-C and a large swollen egg sized and had broken her finger, then this occurred. | 2 830 | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED | |
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| | | | 7. Bolebino. | | С | |
| | | 00568 | B. WING | | 1 | 28/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | threatening to throw was not enough sta supervision with R1 any assessment of determine why she was R1's behaviors assessment of R1's she was, "throwing When interviewed or the state of t | herself off the bed and wherself off the bed. There aff to do one on ones and L. LPN-A was unable to find R1's falls for pattern or to was falling. LPN-A stated it is, but was unable to find any is behaviors to determine why herself," out of bed. | 2 830 | | | |
| | a good system for a are trying to improve should fill out an Incafter each fall. The of these for R1's fasustained on 7/14/2 9/15/20. The DON assessment had no other falls R1 sustained and really rewhich they were unwas unable to prove determine if there what interventions anxiety/behaviors the frequently. No assess of R1's behaviors to may help. | when someone falls and they be this process. The nurse cident Review and Analysis a DON was only able to find 4 lls, which were for the falls 20, 7/31/20, 8/1/20, and did not know why this of been filled out for any of the cined. R1 had behavioral equired one on one attention, able to provided. The DON ide any assessment to was a pattern to R1's falls, and may assist R1 with her nat led to her falling so essment had been completed to determine interventions that | | | | |
| | included severe condiagnosis of demer disturbance. R4 recompobility and dressing for transfer, toileting | Inge MDS dated 8/27/20, gnitive impairment with a hitia with behavioral quired extensive assist for beding and total staff assistance g, and personal hygiene. R4 ent of bladder and rejected | | | | |

| Minnesota Department of Health | | | | | | |
|--------------------------------|--|---|----------------|--|-----------|----------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
| | | | | | | , |
| | | 00568 | B. WING | | 1 | 8/2020 |
| | | 00300 | | | 03/2 | 0/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| DI E 4 0 4 | NT MANOR LLO | 27 BRANI | D AVENUE | | | |
| PLEASA | NT MANOR LLC | FARIBAU | LT, MN 5502 | 21 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | ON. | (X5) |
| PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | D BE | COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO DEFICIENCY) | PRIATE | DATE |
| | | | | DEI IOIENCI) | | |
| 2 830 | Continued From pa | ge 26 | 2 830 | | | |
| | cares 1-3 times during the assessment period. R3 had 1 fall without injury since prior assessment. | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | R4's fall CAA includ | led, "Resident triggers for falls | | | | |
| | r/t having impaired balance, history of falls, and | | | | | |
| | | ation 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 | | | | | |
| | | | | | | |
| | | | | | | |
| | | ntihypertensive, diuretic, | | | | |
| | | otropic medications. She is | | | | |
| | | l and bladder. She has had a | | | | |
| | | . Plan to continue to monitor | | | | |
| | for safety and keep | call light within reach." | | | | |
| | D41ll-4- | d 0/00/00 in directed Fell mink | | | | |
| | | d 6/26/20 indicated, "Fall risk | | | | |
| | | Staff were directed, "Bed in Il light within reach; fall mat. | | | | |
| | | nstruction for mobility | | | | |
| | | t recent intervention, | | | | |
| | | room with FWW [front wheel | | | | |
| | _ | n CGA [contact guard assist] | | | | |
| | | 1 staff] with FWW support" | | | | |
| | | . No additional updates had | | | | |
| | been made. | • | | | | |
| | | | | | | |
| | | ant Care Sheet included, | | | | |
| | |] Hoyer [mechanical lift]; Does | | | | |
| | not ambulate; fall m | nat; call light within reach." | | | | |
| | Dála prograsa a -t- | dated 9/26/20 at 10:51 = : | | | | |
| | | dated 8/26/20, at 10:51 p.m. | | | | |
| | | m nurse aide found resident bed. Resident appeared | | | | |
| | | o bed. Resident appeared and continued to try and | | | | |
| | | Resident swinging arms at staff | | | | |
| | | ion Hoyer [mechanical lift] | | | | |
| | | sisted back up into bed with | | | | |
| | | ff]. Call light was within reach; | | | | |
| | | e next to bed; bed was in | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | |
|---|--|--|------------------------|--|-----------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00568 | B. WING | | 1 | 8/2020 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASAN | IT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| | lit." "Resident receiv Seroquel [antipsych agitation/anxiety an following hour. Hos of nursing], and em notified. Writer and about in-facility fam ease resident's anx contact thought it w Emergency contact visit tomorrow." When interviewed or registered nurse (Rincident report or pofall. R4's care plan R4, as she is no lor When interviewed of family member (FM allowed to visit relation concerned about Rincident report or pofall. No one had possibly visiting to of the bed and mak reach. LPN-D stated R4 harolling from bed. The to the bed and mak reach. LPN-D stated use the call light an intervention. When interviewed of stated, R4 was to his visits after this fall to the DON stated, the DON stated stat | m was clear of clutter and well wed PRN [as needed] notic] for increased d was asleep within the pice, ADON [assistant director ergency contact were all emergency contact talked illy visits in hospices [sic] to ciety/agitation and emergency could be worth a try; is going to try and stop for a con 9/28/20, at 10:00 a.m. N)-A stated there was no cost fall follow-up report on R4's was incorrect about walking neer able to ambulate. In 9/28/20, at 11:35 a.m. I)-B stated they had not been ted to COVID and was 4's falls. FM-B stated R4 o see them out her window for spoken to them about | 2 830 | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | SURVEY PLETED | |
|--|---|---|-------------------------|--|--------------------------------|--------------------------|
| | 00568 | | B. WING | | | C 28/2020 |
| NAME OF PROVIDER OR SUP | PLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASANT MANOR LLC | : | | D AVENUE LT, MN 5502 | 1 | | |
| PREFIX (EACH DEFI | RY STATEMENT OF DEFIC CIENCY MUST BE PRECED Y OR LSC IDENTIFYING IN | CIENCIES DED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| increased fam communicate plan. The fact plans. R3's admission moderate cognincluding a streatensive staff daily living (All of falls prior to admission with delusions or harmonical falls prior to admission with delusions or harmonical falls Resident has following hosp weakness. Horeased right of at this time community. For the daily antihy and hypoglyce of bowel and harmonical for saffollow the falls prior to since admissing something on monitor for saffollow therapy would be communited. R3's Fall Revision and her of falls prior to since admissing something on monitor for saffollow therapy would be communited. | municate the changily visits had not been do to the family or additive was behind in upon MDS dated 8/15/2 mitive impairment with oke and dementia. If assistance with modules, was unsteady, admission and had a no injury. R3 did not allucinations. In dated 8/19/20, includes r/t having impaired, and daily antideprehad a recent decline italization for increase had a CVA [stroke] at side weakness. He with the goal of retirement medications. He has impairing. Resident does admission and has on where he was reast the floor. Plan to confety, keep call light in recommendations. | ded to R4's care odating care 10, included th diagnoses R3 required ost activities of had a history fallen since ot have 11, included th diagnoses R3 required ost activities of had a history fallen since ot have 12, index of fallen the sed risk of falls opic, diuretic, le is incontinent or on the sed risk of falls opic, diuretic, le is incontinent or on the sed risk of falls opic, diuretic, le is incontinent or on the sed risk of falls opic, diuretic, le is incontinent or on the sed risk of falls opic, diuretic, le is incontinent or on the sed risk of falls opic, diuretic, le is incontinent or on the sed risk of falls opic, diuretic, le is incontinent or on the sed risk of falls opic, diuretic, le is incontinent or on the sed risk of falls on, including fall sion, medication on and sensory | 2 830 | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | SURVEY PLETED | |
|--|---|-------------------------------|--|---------|--------------------------|--|
| | 00568 | B. WING | | | C 09/28/2020 | |
| NAME OF PROVIDER OR SUPPLIE | R STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | | |
| PLEASANT MANOR LLC | | D AVENUE LT, MN 5502 | 1 | | | |
| PREFIX (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE | |
| findings or indicated factors would be a R3's care plan darelated to lack of selected to lack of selected factors. R3's cand free from falls Answer call light profession for transfers, followin reach, proper factors were in reach R3's progress not included, "Writer walked in and saw floor. Resident we eating supper. Airesident up using Resident states the dropped and he was wheelchair. Roon the chair that we have the medicing "Pt [patient] was a RN heard some shis wheel chair are saw the resident of R3's progress not "Writer was called floor. Resident was and had his hand. Resident was sitting up. Resident up. Resident was sitting up. Resident was sitting up. Resident up. Resident was si | ance. There was no analysis of ion on how any of these risk addressed. ted 8/12/20, included, "Fall risk safety awareness secondary to goal was, "Resident will be safe s." Staff were directed to, promptly, use a mechanical lift w therapy instructions, call light potwear, ensue frequently used ch. e dated 8/10/20, at 9:31 p.m. was called into room when aid w resident laying prone on the as next to wheelchair and was d, ADON and writer helped hoyer [mechanical] lift. Nat he was eating and his spoon went to go catch it and fell out of esident states he hit his nose was next to the wheel chair." e dated 8/22/20, at 6:55 p.m. Ints door was open and writer ne cart adjacent to the room." attempting at self transfers and ound that was apparently from and no sooner than he turned, he | 2 830 | DEFICIENCY | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | I \ / | SURVEY PLETED | |
|--|---|--|------------------------|---|------------------|--------------------------|
| | | 00568 | B. WING | | | C 28/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | 27 BRAND FARIBAUI | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ge 30 | 2 830 | | | |
| | | al signs were within normal s reminded to use his call light | | | | |
| | R3's progress note dated 9/4/20, 10:32 p.m. included, R3 self transferred and was found sliding off edge of bed. | | | | | |
| | "Resident was layin Resident was holdin waiving it in the air. right next to him wit Resident states he his room and using out of his way. Res wheelchair while do there were no cats assessment of R3's room, even though | dated 9/11/20, included, g on back on the ground. In the ground and Residents wheelchair was the the breaks unlocked. It was chasing the cats out of the handle gripper to get them sident then fell out of bing this." "Resident was told in this facility." There was not belief there were cats in his R3 had not had hallucinations time of the comprehensive | | | | |
| | LPN-C stated other care plan, no new ir any of these falls. It any post fall assess The facility had not determine root caus prevent the falls fro increased confusion not assessed other which the family deinterdisciplinary tean next day and place that assessment, but R3. | on 9/28/20, at 10:31 a.m. than what was already in the nterventions were added after LPN-C was unable to provide sment for any of these falls. assessed each fall to se, nor place interventions to m happening again. R3 had after admission, which was than to offer psych services, clined. Normally, the m would assess each fall the new interventions based upon ut this had not been done for | | | | |
| | When interviewed of | on 9/28/20, at 11:44 a.m. the | | | | |

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--|---|--|---|----------------|--|-------------------|-----------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS REGULATORY OR LSC IDENTIFYING INFORMATION) 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 | | | | A. BUILDING: | | | |
| PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 55021 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) 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 | | | 00568 | B. WING | | I | |
| CAUTION CAUT | NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 | PLEASA | NT MANOR LLC | | | 11 | | |
| 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 | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | LD BE | COMPLETE |
| 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 | DON and RN-A stato provide the docuresident's who had facilities, "Risk marto provide any docures's falls had ever assessed to determine the falls." A facility policy titled Management, revision procedure for staff a fall, "staff will morresident's response intervention put in procedure for staff a fall, "staff will morresident's response intervention put in procedure for staff a fall, "staff will morresident's response interventions. As ne provider will assist not previously ident documented that fawill implement appropried to reflect the fall implement appropried to reflect the fall implement appropried to reflect the fall in the mouth intervention of the fall | ted the facility was not willing mentation related to any of the fallen as it is part of the nagement." They were unable mentation that R1, R4, or been comprehensively nine interventions that may from occurring. d, Fall Prevention and ed 2/2020, indicated follow-up after a resident had sustained nitor and document the eto and the effectiveness of place to prevent further falls for 2. If resident continues to fall, ethe situation and whether it's nue or change the current eded, the resident's medical reconsider possible causes ified. 5. If it is determined and alls may be unavoidable, staff topriate interventions to any from falls. 6. Care plans will et fall interventions." S dated 7/14/20, included the diagnoses of diabetes and required supervision and set eating. The symptomic plans in the ase dysphagia (due to issues evaluation noted R10 was at food or fluids. were made for puree | 2 830 | | | |

Minnesota Department of Health

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Minnesota Department of Health

| AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| A. BUILDING. | | C |
| 00568 B. WING | | 09/28/2020 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S | STATE, ZIP CODE | |
| PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 5502 | 11 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T | D BE COMPLETE |
| (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. R10's Notrition Evaluation dated 4/16/20, identified a mechanical soft diet with pureed meat. 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 | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | |
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| | | | A. BUILDING: | | С | |
| | | 00568 | B. WING | | _ | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ige 33 | 2 830 | | | |
| | desired one. R10 d | led out the burgers and she continued to cough while cked to see if she was alright, g her dentures. | | | | |
| | texture and to provi | ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded | | | | |
| | aide (DA)-A stated mechanical soft die | on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating. | | | | |
| | (CK)-A stated, a me ground meat, no br | on 9/25/20, at 1:12 p.m. cook echanical soft diet should have read or hard vegetables. The responsible to ensure the ed. | | | | |
| | stated R10 does co unaware R10 did no stated if someone is | on 9/25/20, at 1:21 p.m. NA-F ough at meals, she was ot have dentures in. NA-F s coughing like that, they rse to assess if no nurse was | | | | |
| | stated she normally today got a regular grilling them. R10 s dentures, but forgo have to remind her | on 9/25/20, at 1:34 p.m. R10 y gets a ground burger, but whole burger as they were stated she normally wore her t them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H as ok. | | | | |
| | | on 9/25/20, at 3:06 p.m. RN-B ets could be upgraded if they | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING: | | (X3) DATE COMP | SURVEY LETED | |
|---|---|--|------------------------|---|-----------------|--------------------------|
| | | | A. BUILDING: | | | , |
| | | 00568 | B. WING | | | 28/ 2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 830 | risk versus benefits a regular hamburger. When interviewed of Cook-A stated they who had signed a risk for a diet upgrade, they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Gronsistency and papureed food if desire. When interviewed or registered dietician coughing during a risk pool of the pool of | ade, but would have to sign a statement. R10 did not have its statement signed nor was of choking when provided with er today. on 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the sordered and not a regular sion Form provided by Cook-A had been completed by dindicated R10 was to have a round Meat NDD2 diet attent could downgrade to red. on 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to rice director and speech not been done for R10. The provide an upgraded texture eing explained to the resident to 19/28/20, at 2:37 p.m. the ted it is important to provide ture for residents with the serior of the should be notified the ghing. | 2 830 | | | |
| | | S dated 9/4/20, indicated no nt with diagnoses including, | | | | |

Minnesota Department of Health STATE FORM

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--|--|---|------------------------------|--|-------------------|--------------------------|
| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | • | |
| PLEASA | NT MANOR LLC | 27 BRANI FARIBAUI | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | coughing and choki swallowing medicate period. The MDS fur oversite, set up whe altered textures. R5's Speech Theral indicated diagnoses and oral phase dyspindicated R5 had medicated the evaluation had feet dentures that did nowithout dentures, R consistency solids and Advanced. R5 was of materials into the penetration (passage and/or asphyxiation). R5's Care Assessmed ated 1/20/20, indicated 1/20/20, indic | ne MDS noted R5 had ng during meals or when ions during the assessment of the indicated supervision, en eating and mechanically by Evaluation dated 1/25/19, so of cerebral infarction (stroke) ohagia. The evaluation further issing teeth, and at the time of full upper and partial lower of tit. The evaluation indicated 5 could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx,) the ent Area Worksheet (CAA) eated R5 required a diet. There was no analysis noted to proceed to care | 2 830 | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | (X3) DATE COME | SURVEY PLETED | |
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| | | 00568 | B. WING | | 1 | C 28/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | O AVENUE LT, MN 5502 | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 2 830 | R5's Care guide for and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticked Dysphagia Advance further directed to phamburger on bun, vegetables, backed lettuce, soft ice created buring an observation R5 sat alone at a tawhile she attained harmourger whole hamburger whole have been get and having a seizure. Stoof the dining room. When interviewed of stated R5 should have been ground a potato chips or whole when interviewed of stated she has occasing pells," and has not when interviewed of the stated she has occasing pells," and has not when interviewed of the stated she has occasing pells," and has not when interviewed of the stated she has occasing pells," and has not when interviewed of the stated she has occasing pells," and has not when interviewed of the stated she has occasing pells," and has not when interviewed of the stated she has occasing pells," and has not when interviewed of the stated she has occasing pells," and has not when interviewed of the stated she has occasing pells," and has not when interviewed of the stated she has occasing pells," and has not when interviewed of the stated she has occasing pells," and has not when interviewed of the stated she has occasing pells, and has not when interviewed of the stated she has occasing pells, and has not when interviewed of the stated she has occasing pells, and has not when interviewed of the stated she has occasing pells. | r staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, I care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw I beans, no bacon, shredded am and milk. sion on 9/25/20, at 12:50 p.m. able and was noted to cough real. R5's plate contained a with a wedge of lettuce that on a bun and potato chips. I staff throughout the dining ring and dietary, but no one of R5 was coughing. At 12:52 wed to be shaking and asked hurse because she was taff came and brought R5 out the staff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A rave received ground meat, I, soft cooked vegetables. R5 d a bun, the burger should and should not have received be leaf lettuce. | 2 830 | | | |
| | and pureed textures | s. A mechanical diet should no bread or hard vegetables. | | | | |

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE PRETIX (PACH) ID PRETIX TAG CAN ID CAN ID PRETIX TAG CAN ID CAN ID PRETIX TAG CAN ID CAN ID CAN ID PRETIX TAG CAN ID CAN ID PRETIX TAG CAN ID CAN ID CAN ID PRETIX TAG PRETIX TAG CAN ID PRETIX TAG PRETIX TAG CAN ID PRETIX TAG PRETIX TAG PROVIDERS PLAN OF CORRECTION (CAN ID PRETIX TAG CAN ID PRETIX TAG PRETIX TAG PRETIX TAG PROVIDERS PLAN OF CORRECTION (CAN ID PRETIX TAG CAN ID PRETIX TAG PRETIX TAG PREVIDERS PLAN OF CORRECTION (CAN ID PRETIX TAG PRETIX TAG PREVIDERS PLAN OF CORRECTION (CAN ID PRETIX TAG PROVIDERS PROVIDERS PRANCE TAG PROVIDERS PRO | | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|-----------|---|---|--------|---|-------|-------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 55021 (X4) ID PREFIX (EACH DEPTICENCY MUST BE PRECEDED BY FULL PREFIX TAG.) (EACH DEPTICENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION BROULD BE CROSS-REFIRED BEFICIENCY). 2 830 Continued From page 37 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 egiting 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 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 die, 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 or 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 | | | 00500 | | | 1 | | |
| RAND AVENUE FARIBAULT, MN 5021 | | | | | | 09/2 | 8/2020 | |
| PALESANT MANOR LLC | NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| QNJID SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION CIRCH DEFICIENCY WILST BE RECEDED BY FULL PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE | PLEASA | NT MANOR LLC | | _ | 21 | | | |
| 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 | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | .D BE | COMPLETE | |
| reviewed quarterly. | 2 830 | For the noon meal mechanical texture ground hamburger, was the cook's respresident is getting the wasted staff should coughing and should have received the who gave her the way When interviewed to bietary Aide-A reposited a resident is upgraded texture if been signed. The recorder from the physiand benefit form. Round have received to the cook is responded to the cook | provided on 9/25/20, a should have included, no bun, potato salad and beans. It consibility to make sure a ne appropriate texture. In 9/25/20, at 1:21 p.m. NA-Fincheck on residents who are led get a nurse. R5 should correct diet and did not know rong diet. In 9/25/20, at 1:40 p.m. red both dietary and nursing grays. In 9/25/20, at 3:06 p.m. RN-B ok to be provided an a risk and benefit form had esident should be given the sician if there is no signed risk 5 did not have a signed form. In p.m. Cook-A- stated R5 and the ordered diet, but did aponsible for providing the of Care/Interventions, Risk dated 9/11, identified a nformed of the risk and any care and given the ng their decision in the plan of would be approached 2-3 at continued to refuse, and be made on the Refusal of | 2 830 | DETIONENCY) | | | |

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Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | | | | |
| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 11 | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | | COMPLETE DATE |
| 2 830 | Continued From pa | ge 38 | 2 830 | | | |
| | | ically Altered. All foods on | | | | |
| | | l. Meats and other select nd or minced into small pieces | | | | |
| | no larger than one | forth inch. All food items | | | | |
| | | thew. Meats should be | | | | |
| | | or cooked meat, poultry, or 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 | | | | | |
| | | | | | | |
| | | ables should be less than 1/2 easily mashed with a fork. | | | | |
| | mon and should be | casily mastica with a fork. | | | | |
| | SUGGESTED MET | HOD OF CORRECTION: | | | | |
| | | sing or designee, could | | | | |
| | review/revise policie | es and procedures related to | | | | |
| | | resident supervision to assure and interventions are being | | | | |
| | | ne provider is promptly notified | | | | |
| | | dition. They could re-educate | | | | |
| | | and procedures. A system monitoring consistent | | | | |
| | | hese policies could be | | | | |
| | | results of these audits being | | | | |
| | brought to the facility Committee for review | ty's Quality Assurance | | | | |
| | | | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 905 | MN Rule 4658.052 | 5 Subp. 4 Rehab - Positioning | 2 905 | | | 11/2/20 |
| | | g. Residents must be | | | | |
| | | body alignment. The position to change their own position | | | | |
| | | t least every two hours, | | | | |

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Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
|--------------------------|--|--|---------------------|--|-----------|--------------------------|
| ANDILAN | OF CONTRECTION | IDENTIFICATION NOMBER. | A. BUILDING: | | | |
| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | 27 BRAND | | | | |
| | | | LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 905 | Continued From pa | ge 39 | 2 905 | | | |
| | including periods of been put to bed for has documented th hours during this tir | time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or rdered a different interval. | | | | |
| | by: Based on observati review, the facility fa timely for 1 of 3 res | on, interview, and document ailed to provide repositioning idents (R4) reviewed who eloping pressure ulcers. | | Area acknowledged | | |
| | Findings include: | | | | | |
| | dated 8/27/20, incluimpairment with a drequired extensive a total staff assistance | nge Minimum Data Set (MDS) ided severe cognitive liagnosis of dementia. R4 assist for bed mobility and e for transfer. R4 was at risk levelopment, but did not have ulcer. | | | | |
| | (CAA) dated 8/28/2 for pressure r/t [relawith bed mobility ar incontinence. Resided own r/t cognitive in HTN [hypertension] and daily use of AS [blood thinner]. She bladder. Resident nover skin tear on LL otherwise intact. Preplace with toileting a hours, pressure recombed of the pressure recomb | Care Area Assessment 0 included, "Resident triggers ated to] need for assistance and bowel and bladder dent is at risk for skin break impairment, dx [diagnosis] of and Type 2 DM [diabetes] A [aspirin] and Coumadin is incontinent of bowel and acted to have scabbed area LE [lower left extremity]. Skin eventative skin measures in and repositioning q [every] 2 distribution cushion to ttress to bed, routine skin [morning] and HS [night], and | | | | |

Minnesota Department of Health

STATE FORM 2XHN11 If continuation sheet 40 of 49

Minnesota Department of Health

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|------------------------|--|-------------------|--------------------------|
| | | | A. BOILDING. | | | , |
| | | 00568 | B. WING | | 1 | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 905 | alteration in skin int "Monitor skin integrinspection by nurse order. Pressure redistribut chair." Care plan in R4's care plan furth mobility related to e "Dependent with be staff]. Maxi lift (Hoy transfers. Turn and hours]." Additionally "Alteration in comfo 9/8/20: "Position q2 [as needed] with pil R4's nursing assist: "Assist of 2 w/ [with not ambulate." The on how often to ass repositioning. A Hospice Facility \ 9/3/20 included, "Di to bottom." During continuous starting at 10:25 a.i herself in the wheel effectively adjust he members asked R4 R4 verbally decline offered to recline R declined. No encouprovided. No addition | d 6/26/20 included, "Potential egrity." Staff were directed to, ity daily. Weekly skin and the common to open areas per listribution mattress to bed. Ition cushion to wheelchair, the terventions updated 9/1/20. Iter indicated, "Alteration in and of life" with interventions: and mobility: A1-2 [assist of 1-2 der) [mechanical lift] with reposition Q2H [every 2 of R4's care plan specified, ort," with an intervention dated thrs [every 2 hours] and PRN | 2 905 | | | |

Minnesota Department of Health

STATE FORM 2XHN11 If continuation sheet 41 of 49

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 [EACH DEPICIENCY MUST BE PRECEDED BY FULL RESULATORY OR 150 (RETHEY HAVE INFORMATION) RESULATORY OR 150 (RETHEY HAVE INFORMATION) 2 905 Continued From page 41 2 905 Continued From page 41 2 905 Continued From page 41 Sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining room. At 1:55 p.m. rursing 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 not had time to assist R4 to lie down or reposition since getting her up at 7:30 a.m. NAF- 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 bed should be on an every 1 hour (g1 hour) repositioning schedule. Residents who are in a chair should be on an every 1 hour (g1 hour) repositioning schedule. Residents who are in a chair should be on an every 1 hour (g1 hour) repositioning schedule. Residents who are in a chair should be on an every 1 hour (g1 hour) repositioning schedule. Residents who are in a chair should be on an every 2 hour (g2 hour) repositioning schedule. Residents who are in a chair should be on an every 2 hour (g2 hour) repositioning schedule. | | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE | SURVEY |
|--|----------------|--|--|----------------|--|-----------|----------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 (X4) ID (X4) ID (EACH DEPTICENCY MUST BE PRECEDED BY FULL TAG CROSS-REPERBENCE A COMMAN IN THE PRECEDED BY FULL SUBJECT ON THE SECONDAY OR 150 (EXHTPYNG INFORMATION) 2 905 Continued From page 41 sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining room. At 1:55 p.m. rursing 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 bed should be on an every 1 hour (q1 hour) repositioning schedule. Residents who are in a chair should be on an every 1 hour (q2 hour) repositioning schedule. Residents who are in a chair should be an an every 2 hour (24 hour) repositioning schedule. Residents who are in a chair should be on an every 1 hour (q2 hour) repositioning schedule. Residents who are in a chair should be on an every 2 hour (q2 hour) repositioning schedule. | 71110 1 127111 | OF CONTRECTION | IBERTII IOATION NOMBER. | A. BUILDING: | | | |
| PLEASANT MANOR LLC (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 905 Continued From page 41 sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining 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 an every 2 hour (q2 hour) repositioning schedule. Residents who are in bed should be on an every 2 hour (Q2 hour) repositioning schedule. Residents who are in bed should be on an every 2 hour (Q2 hour) repositioning schedule. Residents who are in bed should be on an every 2 hour (Q2 hour) repositioning schedule. Residents who are in bed should be on an every 2 hour (Q2 hour) repositioning schedule. | | | 00568 | B. WING | | | _ |
| CK4 ID CK4 ID CK5 ID C | NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 905 Continued From page 41 sugar and administer insulin. R4 was not repositioned. LPN-D brought R4 to the dining 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, "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 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 an every 2 hour (q2 hour) repositioning schedule. "Facility policy Skin Assessment and Wound Management (revision date 1 state and every 2 hour (q2 hour) repositioning schedule." Facility policy Skin Assessment and Wound Management (revision date 1 state and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour (Management (revision date 1 state) and every 2 hour | PLEASA | NT MANOR LLC | | _ | 21 | | |
| 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 set should be on an every 2 hour (q2 hour) repositioning schedule. "Facility policy Skin Assessment and Wound Management (revision date 7/2018) | PRÉFIX | (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR | ULD BE | COMPLETE |
| identified "A weekly skin inspection will be completed by licensed staff." SUGGESTED METHOD OF CORRECTION: | 2 905 | sugar and administ repositioned. LPN-I room. At 1:55 p.m. NA-B assisted R4 in bed using 2 pillows stated, "Oh God, the pain was in her back." When interviewed cand NA-B stated the morning cares at 7: not had time to assince getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge the same position in repositioned. R4 slehours. When interviewed codirector of nursing (repositioned every): The facility policy R5/2013) identified, "resident who is immediate for repositioning." T "Residents who are every 1 hour (q1 hor Residents who are an every 2 hour (q2 schedule." Facility policy R5/2014) wound Manageme identified "A weekly completed by license." | er insulin. R4 was not D brought R4 to the dining nursing assistant (NA)-F and nto bed and positioned her in . As R4 was laid in bed she at hurts." R4 specified that the ek. on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with .30 a.m. NA-F stated they had ist R4 to lie down or reposition of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours in the rehair without being hould be repositioned every 2 on 9/28/20, at 3:05 p.m. the (DON) stated R4 should be 2 hours. Repositioning (revision date Repositioning is critical for a mobile or dependent upon staff The policy further instructs, in a chair should be on an our) repositioning schedule. In bed should be on at least 2 hour) repositioning schedule. In bed should be on at least 2 hour) repositioning schedule. In bed should be on at least 2 hour) repositioning schedule. In bed should be on at least 2 hour) repositioning schedule. In section will be sed staff." | 2 905 | | | |

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 905 | The director of nursall residents at risk they are receiving the treatment/services from developing an pressure ulcers. The designee, could condelivery of care; to services are implementations. | sing or designee, could review for pressure ulcers to assure he necessary repositioning to prevent pressure ulcers d to promote healing of the director of nursing or anduct random audits of the ensure appropriate care and nented; to reduce the risk for | 2 905 | | | |
| 2 920 | Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily livi | is unable to carry out ing receives the necessary n good nutrition, grooming, | 2 920 | | | 11/2/20 |
| | by: Based on observati review, the facility fa care timely, and fail status after a signifi | ent is not met as evidenced on, interview, and document ailed to provide incontinence led to reassess continence icant change for 1 of 3 ewed for incontinence. | | area acknowledged | | |
| | 6/29/20, included, n with diagnoses included | nimum Data Set (MDS) dated moderate cognitive impairment uding diabetes, dementia and extensive assistance with | | | | |

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Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
|--------------------------|--|--|-------------------------|---|-----------|--------------------------|
| AND FLAN | OF CONNECTION | IDENTIFICATION NOWIDER. | A. BUILDING: | | | |
| | | 00568 | B. WING | | 09/2 | ; 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | O AVENUE LT, MN 5502 | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T | D BE | (X5) COMPLETE DATE |
| 2 920 | toileting and limited hygiene. R4 was no was occasionally intimes during the assistance with toile incontinence." "She and OT [occupation the goal of returning uses incontinence process incontinence of the | assistance with personal of on a toileting program and continent of urine (less than 7 sessment period). Care Area Assessment (CAA) red, "Resident triggers for et use and bladder is in PT [physical therapy] and therapy] at this time with go to the community. Resident products to aid in keeping sking to with current toileting plant reares q [every] AM [morning], each incontinent episode." The MDS dated 8/27/20, gonitive impairment, was totally aff for toileting and personal ways incontinent of urine. CAA dated 8/28/20 included, for urinary incontinence r/t er incontinence. Resident has bility and cognitive function. The relation of the products to dry. Plan to continue to with the and complete peri cares questions. The relation of the products to dry. Plan to continue to with the and complete peri cares questions. The relationship is and with each the dated 6/24/20, and indicated followed and bladder. | 2 920 | | | |
| | "Alteration with elim | ination." Staff were directed toileting." The care plan had | | | | |

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Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|-------------------------|--|-------------------|--------------------------|
| | | | A. BUILDING. | | | , |
| | | 00568 | B. WING | | | 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | 27 BRAND FARIBAUI | O AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 920 | not been updated s 8/27/20, MDS noted incontinence to total in assistance needs hygiene. R4's nursing assistance needs hygiene. R4's nursing assistance needs hygiene. R4's nursing assistants of the second provided. No information and starting at 10:34 a.r. if she would like to declined. No encouprovided. No addition incontinence cares licensed practical inher room to check linsulin. LPN-D then room. Incontinence 1:58 p.m. NA-F and and changed R4's with the work of the second provided. When interviewed and NA-B stated the morning cares at 7: not had time to assince getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge without being assis When interviewed of the second provided in the second provided in the second provided p | ince 6/26/20, even though the d a decline in urinary ally incontinent and an increase of for toileting and personal ant Care Sheet included, are [mechanical lift]; does not remation was included to direct on how to attend to R4's abservation on 9/25/20, and 2 staff members asked R4 lay down. R4 verbally ragement or re-approach was onal attempts to provide occurred. At 11:46 a.m. urse (LPN)-D brought R4 to blood sugar and administer brought R4 to the dining cares were not provided. At INA-B assisted R4 into bed | 2 920 | | | |
| | | with incontinent cares every 2 rated she did not know R4's | | | | |

Minnesota Department of Health

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) I

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
|--------------------------|--|---|------------------------|--|-----------|--------------------------|
| 741012741 | or contraction | BENTI IO NI ON NOMBER. | A. BUILDING: | | | |
| | | 00568 | B. WING | | 09/2 | ; 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 920 | was present review and Bladder assess 6/24/20, noting it in bladder. RN-A review identified R4 had not bladder assessmer significant decline in June of 2020. RN-an updated assessichange MDS compexplained they were R4 was on their wo should have been of changed at least event and the street of th | egistered nurse (RN)-A who wed R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and of had an updated Bowel and of had an expectation of had a not condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A to behind on assessments and rk list, "to be caught up." R4 checked for incontinence and very 2 hours. The facility policy Care date 6/2019) identified "The hodified and updated as the needs of the resident THOD OF CORRECTION: sing and/or designee could procedures and educate provide care to residents' by staff, based on residents' assessed needs. The DON or induct audits of dependent insure their personal care | 2 920 | | | |

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|-----------------------|--|-------------------|--------------------------|
| | | | A. BUILDING: | | | , |
| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | 27 BRANI FARIBAUI | AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21810 | Continued From pa | ge 46 | 21810 | | | |
| 21810 | MN St. Statute 144 Residents of HC Fa | .651 Subd. 6 Patients & ac.Bill of Rights | 21810 | | | 11/2/20 |
| | residents shall have medical and persor needs. Appropriate care designed to er highest level of phy This right is limited | riate health care. Patients and eithe right to appropriate hal care based on individual ecare for residents means hable residents to achieve their sical and mental functioning. Where the service is not blic 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. | | | area acknowledged | | |
| | Findings include: | | | | | |
| | 7/28/20, included m with a diagnosis of incontinent and req | nimum Date Set (MDS) dated noderate cognitive impairment a stroke. R7 was occasionally uired assistance by one staff on and off of the toilet. | | | | |
| | Rehab Care Assess dated 9/25/20, included in mobility, | of daily living)/Functional sment Area Worksheet (CAA) uded, R7 has had a recent was occasionally incontinent er, and needed assistance for est. | | | | |
| | required assistance dependent assist, or | d 7/29/20, included, R7 e for, "Bathing with max to dressing with max assist, et-up with minimal assist, | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|-------------------------|--|-------------------------------|--------------------------|
| | | | A. BOILDING. | | | |
| | | 00568 | B. WING | | 1 | , 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | .1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 21810 | occasionally incontivith toilet use." When Interviewed was lying in bed. Rifacility is very bad. there seems to be infacility. Call lights chour. I push the call bathroom and no owet myself. I feel his chair and embarras cleaned up and chabrow was furled an R7 stated this happ. When interviewed on ursing assistant (Now wait for assistance her incontinent. This Most residents wait time to receive an a has assisted R7 aft secondary to waiting time for the call light that there have been beginning of the should and need as night shift is custom one licensed praction urse (RN) for the facility. When interviewed of LPN-D state there is individual needs of among staff and residents. | on 9/25/20, at 2:00 p.m. R7 restated, "Staffing for the labame the State because no staffing guidelines for this an go unanswered for over an light when I need to go to the ne comes until it is too late. I umiliated about wetting in the sed about needing to be anged." R7 looked angry, her did her face became slightly rediens at least once a week. On 9/25/20, at 2:35 p.m. NA)-D stated R7's often has to to the bathroom which makes is was always upsetting to R7. If for an extended period of answer to their call light. NA-D for a prolonged period of answer to their call light. NA-D for a prolonged period of answer to their call light. NA-D for a prolonged period of answer to their call light. NA-D for a prolonged period of answer to their call light. NA-D for a prolonged period of answer to their call light. NA-D for a prolonged period of answer to their call light. NA-D for a prolonged period of answer to their call light. NA-D for a prolonged period of answer to their call light. NA-D for a prolonged period of an arily staffed with two NA's and call nurse (LPN) or registered and a call nurse (LPN) or registered a current residents in the sidents is low because of this. In the due to not being able to get | 21810 | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---|---|-------------------------------|--------------------------|
| | | 00568 | B. WING | | 09/2 | ; 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 1 00/2 | 0/2020 |
| PLEASA | NT MANOR LLC | 27 BRANI FARIRALII | AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 21810 | 9/22/20, at 3:51 a.m showed the call light the seven day periodinitiated, 11 (or 21.5 15 minutes to receit 14%) of these alerts to receive a responsible. During a phone call p.m. the administration staffing or facility as determining staffing administrator stated include one staff me "More comradery a was needed among would improve care they are working or SUGGESTED MET. The administrator, of designee could revien sure residents retimely fashion. It coresidents that may concern. The facility changes, and audit needs of resident(saudits for an amour quality assessment improvement (QAP compliance. The accould then take that assess need for fur | nse time logs dated from n. to 9/28/20, 9:25 a.m. It was engaged 51 times over Id. Of the 51 call light alerts Id. Of these alerts took over Id. Of these al | 21810 | DETIGIENCI!) | | |
| | (21) days. | | | | | |

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|------------------------|---|-------------------|--------------------------|
| 7.1.12 . 27.11 | | | A. BUILDING: | | | |
| | | 00568 | B. WING | | 09/2 | ; 8/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | ****ATTEI | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | nether a violation has been | | | | |
| | that may result from orders provided tha the Department with | hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance. | | | | |
| | survey was conduct with State Licensure NOT in compliance Please indicate in y correction that you | TS: 2) and 9/28/20, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. Our electronic plan of have reviewed these orders, e when they will be completed. | | | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|---------------|---|--|----------------|---|-------------------|------------------|
| | | | A. BOILDING. | | | ` |
| | | 00568 | B. WING | | | , 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | O AVENUE | 14 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | LT, MN 5502 | PROVIDER'S PLAN OF CORRECTION | ON. | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | COMPLETE DATE |
| 2 000 | Continued From pa | ge 1 | 2 000 | | | |
| | SUBSTANTIATED H5090056C: MN R H5090057C MN RU Rule 4658.0525 Su H5090059C MN RU Rule 4658.0525 Su 4658.0525 Subp.4 | plaints were found to be with a licensing order issued: ule 4658.0520 Subp. 1 and MN bp. 6 B alle 4658.0510 Subp. 1; MN bp. 6 B.; and MN Rule | | | | |
| | unsubstantiated: H | 5090055C and H5090058C ed in ePOC and therefore a uired at the bottom of the first | | | | |
| 2 800 | MN Rule 4658.0510 Staffing requiremen | O Subp. 1 Nursing Personnel; nts | 2 800 | | | |
| | home must have or number of qualified registered nurses, I nursing assistants t residents at all nurs in all buildings if mo | requirements. A nursing a duty at all times a sufficient nursing personnel, including icensed practical nurses, and to meet the needs of the ses' stations, on all floors, and one than one building is udes relief duty, weekends, tements. | | | | |
| | by: Based on observation review, the facility for staffing to provide for planned needs for 8 R1, R3, R8, R13 ar | ent is not met as evidenced on, interview and document ailed to ensure sufficient or the individualized care B of 8 residents (R5, R7, R4, and R12), 12 of 15 staff (LPN-B, -D, NA-C, NA-J, NA-B, NA-F, | | | | |

Minnesota Department of Health

STATE FORM 6899 2XHN11 If continuation sheet 2 of 49

Minnesota Department of Health

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
|--------------------------|--|---|------------------------------|--|-------------------|--------------------------|
| | | 00568 | B. WING | | 09/2 | 2 <mark>8/2020</mark> |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | Continued From pa | ge 2 | 2 800 | | | |
| | members (FM)-A, | A and NA-C) and 1 of 3 family reviewed for sufficient staffing. ial to affect all 42 current | | | | |
| | Findings include: | | | | | |
| | included cognitively stroke with paralysis the body and a seiz | num Data Set dated 9/4/20, intact with diagnoses of s or weakness on one side of ure disorder. R5 required from staff for toileting and | | | | |
| | 1/20/20, included, | nt Worksheet (CAA) dated R5 extensive assistance with ing (ADL) including bathing | | | | |
| | needed assistance shower/bath with or | ated 8/12/20, included, R5 with toilet use and ne assist twice a week on esday evenings with skin | | | | |
| | licensed practical n not getting the time toileting, bathing an | on 9/24/20, at 12:23 p.m. urse (LPN)-A stated, R5 was ly care she needed with d hygiene as there was not id complain about this. | | | | |
| | stated, "This facility over an hour to get R5 stated it takes a the bathroom, and, Sunday and a show would rather I just to less time and effort | on 9/24/20, at 2: 20 p.m. R5 is very short staffed. I wait an answer to my call light." long time to get help to go to "I should have a bath every ver every Wednesday. The aid ake a shower because it takes . Sometime, I get neither nere are not enough aids on." | | | | |

Minnesota Department of Health

STATE FORM 6899 2XHN11 If continuation sheet 3 of 49

Minnesota Department of Health

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|---|---------------------|--|-------------------|--------------------------|
| | | 00568 | B. WING | | 09/2 | ; 8/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | • | |
| PI FASA | NT MANOR LLC | 27 BRAND | | | | |
| 1 EEAGA | | | _T, MN 5502 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 800 | Continued From pa | ge 3 | 2 800 | | | |
| | This was upsetting | to R5. | | | | |
| | When interviewed on ursing assistant (Nassistance with bat she had to wait for have enough staff the Sometimes they had on not have enough when interviewed of licensed practical in complained of not obasis. This was up doing the best they receive a bath of stated, "R5's showed evening due to time did not get done due bath requires two an only two on the flood had a lot to do and time to get in the bath another shower that that we never got described again until 8/17/20, 8/24//20. R5 received again until 9/21/20. Review of R5's call | on 9/24/20, at 3:22 p.m. a NA)-D stated R5 required hing and toileting, but often assistance as they do not o get to everyone timely. Ve to skip R5's bath as they in time. on 9/24/20, at 3:45 p.m. a urse (LPN)-B stated, R5 getting her shower on a regular setting to her, but they were could. Incern Report included, R5 did or shower on 7/22/20. NA-I er did not get done on Sunday e." NA-J stated, "R5's shower e to running out of time. Her ids which [NA-I] and I were the r until 6 p.m. After 6 we still ended up not having enough ath R5 wanted. There was also t was supposed to get done one." Is dated July to September a shower on 7/19 but not and then not again until ed a bath on 9/13/20, but not | | | | |
| | the call light 166 tim | nes. Of the 166 instances, the 20 minutes on 69 occasions or | | | | |

6899

Minnesota Department of Health

| STATEMENT OF C | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--|---|---|-------------------------|--|-------------------|--------------------------|
| | | | A. BOILDING. | | | |
| | | 00568 | B. WING | | | , 8/2020 |
| NAME OF PROV | VIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASANT MANOR LLC | | 27 BRANI FARIBAUI | O AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| R7 mo of a received training the second with the second we change the second we second with the second wit | oderate cognitive a stroke. R7 was quired assistance insfer on and off of a stroke. R7 was quired assistance and Care Assessited 9/25/20, included in mobility, who well and bladded leting upon requerally in the cassistance approached assistance are plan dated as in the cassistance are plan dated as in a cassistance are plan bear and and no or at myself. I feel he can are and and and and are are and and and characteristic and and and are are are and and and and are are are are are and and and and are | S dated 7/28/20, included impairment with a diagnosis occasionally incontinent and by one staff person to of the toilet. of daily living)/Functional sment Area Worksheet (CAA) ded, R7 has had a recent was occasionally incontinent er, and needed assistance for est. d 7/29/20, included, R7 for, "Bathing with max to ressing with max assist, et-up with minimal assist, nent, and requires assistance on 9/24/20, at 1:31 p.m. a IA)-C reported the previous soiled halfway up her back er shift. NA-C reported there ff to meet R7's toileting and | 2 800 | | | |

6899

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY |
|--------------------------|--|---|-------------------------|---|-------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00568 | B. WING | | 09/2 | 28/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 800 | nursing assistant (N wait for assistance her incontinent. Thi Most residents wait time to receive an a has assisted R7 aft secondary to waitin time for the call light that there have been beginning of the sh soiled and need as night shift is custom one licensed praction nurse (RN) for the afacility. When interviewed a LPN-D stated there the individual needs morale among staff of this. R7's call light responsationally assistance, and the seven day periodinitiated, 11 (or 21.5 minutes to receive a responsationally and demential assistance with mo (ADL's) and did not | on 9/25/20, at 2:35 p.m. NA)-D stated R7's often has to to the bathroom which makes is was always upsetting to R7. For an extended period of answer to their call light. NA-D er R7 was incontinent in g for a prolonged period of it to be answered. NA-D stated in, "Too many times," at the iff when several residents are sistance. NA-D stated the narily staffed with two NA's and call nurse (LPN) or registered the narily staffed with two NA's and call nurse (LPN) or registered to deach resident. The fand residents is low because in the second resident. The fand residents is low because on the second of the 51 call light alerts fow of the 51 call light alerts fow of these alerts took over over a response. Seven (or is took longer than 20 minutes second of the S1 (MDS) dated devere cognitive impairment and the second of the S1 (MDS) dated devere cognitive impairment and TBI (traumatic brain and R1 required extensive is activities of daily living ambulate. R1 had 2 or more et the prior assessment. R1 | | | | |

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STATE FORM 6899 2XHN11 If continuation sheet 6 of 49

Minnesota Department of Health

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
|--------------------------|--|---|------------------------------|--|-------------------|--------------------------|
| | | 00568 | B. WING | | 09/2 | 2 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | R1's care plan date AEB [as evidenced admission related to secondary to TBI and disturbances." The "Resident will be sa should incident occ "Provide one on one and wheeling her do The facility provided from 7/21/20 thorou R1 had fallen in the frame. 7/14/20, 7/3 8/11/20, 8/12/20, 8/ 8/16/20, 8/19/20, 8/ 9/14/20 and 9/15/20 Hospital discharge indicated R1 was tr 9/15/20 after sustai agitation. Summary fractured skull and R1's progress notes revealed: -9/16/20, at 4:36 p.f from the hospital. R1's progress note included R1 had att several times after Facility transferred started to yell out an and back. R1 repor neck and back. R1 wheelchair. Facility ratio as the facility of R1's physician was | d 9/2/20, included, "Fall risk by] multiple falls since o lack of safety awareness and Dementia with behavioral goal for R1 was listed as, afe and free from serious injury ur." Staff were directed to, e care, such as taking outside own the hall." d a running list of R1's falls ugh 9/24/20, which indicated facility 17 times in that time 1/20, 8/1/20, 8/5/20, 8/6/20, 12/20, 8/16/20, 8/16/20, 9/3/20, 0. summary dated 9/16/20, ansferred to the hospital on ning a fall related to increased of details R1 incurred a | 2 800 | | | |

Minnesota Department of Health

STATE FORM 6899 2XHN11 If continuation sheet 7 of 49

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|---|------------------------------|--|-------------------|--------------------------|
| | | 00568 | B. WING | | 09/2 | 28/2020 |
| | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | FARIBAU | LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | Continued From pa | ge 7 | 2 800 | | | |
| | | lian was informed of the | | | | |
| | included, R1 was tra full report was given teams. The floor nu | dated, 9/16/20, at 6:24 p.m. ansferred back the hospital. A n to the police and transport arse called the hospital to returning to them due to | | | | |
| | included, R1 was no marked behaviors: put herself onto the louder than her usu and 1:1, 2:2, 3:3 we remained aggressiv 911 to send R1 to e | d dated 9/16/20, at 6:28 p.m. oted to have continued swore at staff, attempted to floor, yelling and hollering al, R1 was extremely agitated are attempted and R1 ve towards staff. Facility called mergency department (ED) in per physician's orders. | | | | |
| | stated there were ti one attention, but the | on 9/24/20, at 1:00 p.m. NA-B mes when R1 required one on ney only had one or two staff to esidents, so this was not | | | | |
| | | on 9/24/20, at 1:31 p.m. NA-C have enough help to watch R1 efell a lot. | | | | |
| | emergency room so would not take R1 k | on 9/24/20, at 2:56 p.m. the ocial worker stated the facility back to the facility because nough help to watch her well | | | | |
| | stated R1 required time to prevent her | on 9/24/20, at 3:22 p.m. NA-D a significant amount of staff from falling and they just did a stay with her all the time. | | | | |

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STATE FORM 6899 2XHN11 If continuation sheet 8 of 49

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|---|------------------------|--|-------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00568 | B. WING | | 09/2 | , 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | Continued From pa | ge 8 | 2 800 | | | |
| | NA-D stated she we when arriving for he wet," in her inconting | orked the day shift and often er shift would find R1, "sopping ent brief. | | | | |
| | stated there was no | on 9/24/20, at 3:45 p.m. LPN-B ot enough staffing to supervise afe as she required individual | | | | |
| | DON stated due to could not be met at | on 9/28/20, at 10:10 a.m. the limited staffing R1's needs the facility, therefore R1 could fter her last admission to the | | | | |
| | 8/15/20, revealed R impairment. R3 req staff physical assist diagnosis included swallowing concern mouth when eating mouth/cheeks or re | nimum data set (MDS), dated as had moderate cognitive uired supervision and one tance for eating. R1's a stroke. R3 had the following as: loss of liquids/solids from or drinking, holding food in esidual food in mouth after ag during meals or when tions. | | | | |
| | staff, "The resident with adequate eatin all meals in the dini | updated 9/24/20, directed needs a calm, quiet meal time of time. The resident requires ng room r/t [related to] close eceive meals until supervision | | | | |
| | stated she worked "understaffed." NA be provided mornin especially if they re assistance with me | on 9/24/20, at 12:56 p.m. NA-A day shift and considered it, -A reported residents waited to g cares prior to breakfast, quired two staff and chanical lift. NA-A stated, R3 assistance for cueing him to | | | | |

Minnesota Department of Health

STATE FORM 6899 2XHN11 If continuation sheet 9 of 49

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|------------------------------|--|-------------------|--------------------------|
| | | 00568 | B. WING | | 09/2 | 28/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | • | |
| PI FASA | NT MANOR LLC | | O AVENUE | | | |
| I LLAGA | IN MANOR LLO | FARIBAU | LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 800 | Continued From pa | ge 9 | 2 800 | | | |
| | not eat too quickly of get enough fluid. Not over 40 minutes to in the dining room to | or take too big of a bite and to A-A noted R3 often had to wait eat until they had enough staff o help him. | | | | |
| | stated, R3 required make sure he ate the staff were available | on 9/24/20, at 3:22 p.m. NA-D staff to closely monitor to ne amount he should. Often no to help, he would sit and look aiting for his plate of food. | | | | |
| | stated, there were s assistance in the di to figure out how to entire time due to c | on 9/24/20, at 3:45 p.m. LPN-B several residents that required ning room and it was difficult feed R3. R3 required help the hoking precautions and the entire meal time. | | | | |
| | wheeled self into the wheel chair back ar | on 9/25/20, at 12:21 p.m. R3 e dining room. R3 rolled his nd forth at the table, looking al was brought to him at 12:41 | | | | |
| | stated there is never room to feed everyout lucky to have 2 aide R8's admission MD was cognitively inta Parkinson's disease assistance of 2 staff | on 9/25/20, at 1:21 p.m. NA-F or enough staff in the dining one. "On a good day, we are es to assist all the residents." S, dated 8/10/20, included, R8 ct with a diagnosis of e. R8 required physical of for transfers and supervision vsical assistance for toileting. | | | | |
| | staff, "Alteration in e Parkinson's" and, "A needed for hygiene | | | | | |
| | When interviewed of | on 9/24/20, at 12:23 p.m. | | | | |

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE | SURVEY |
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| 712 . 271 | o. oo20 | | A. BUILDING: | | | |
| | | 00568 | B. WING | | 09/2 | : 28/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
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| 2 800 | the morning and neafternoon. LPN-An her call light on but When interviewed of stated, "We barely more independent aresidents who requive when interviewed of stated there was now when she needed it with stiffness and don her own when helate. R8 stated stated on each side of the but it is often over to they do not have entime. R8 stated should be bathroom, she minutes to get on other back to hurt and unable to care for helated August 2020, Carbidopa-Levodop Parkinson's disease stiffness, tremors, secontrol) five times of 4:00 p.m., 7:30 p.m. noted as being administration. | as independent with cares in seded more assistance in the oted R8 might not even turn holler out for staff. on 9/24/20, at 12:56 p.m. NA-A touch base," with R8 as she is and staff need to help with irred more assistance. on 9/28/20, at 10:37 a.m. R8 of enough staff to help her t. R8 stated she has problems ecreased ability to do things er Parkinson's medication was ff tell her they have a half hour time her medication is due, hat. R8 stated staff tell her nough staff to get it to her on e does not get enough help to often has to wait 20-40 r off the toilet. This causes d she gets even more still and | 2 800 | | | |
| | LPN-D stated R8 w time. LPN-D stated | on 9/28/20, at 10:58 a.m. ranted her medications on the R8 reported concerns with ions on time in the evening. | | | | |

Minnesota Department of Health STATE FORM

STATE FORM 2XHN11 If continuation sheet 11 of 49

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 SUMMARY STATEMENT OF DEFICIENCIES PRETRY TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DEATIFYING INFORMATION) 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. | | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
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| PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 55021 (X4) ID SUMMARY STATEMENT OF DEFICIENCY SERVICES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 800 Continued From page 11 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. | | | 00568 | B. WING | | | |
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| 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 | 2 800 | R8's call light log, dincluded, R13 activatwo incidents, the reand 40 minutes. On time was between 4 incident, the responsively intact wisclerosis. R13's quarterly MD cognitively intact wisclerosis. R13 requives incontinent of the R13's care plan, darisk for skin breakd assistance. The carcall light in reach are When interviewed astated R13 was totacares. Sometimes be breakfast as they diner up before breakfast | ated 9/8/20 through 9/25/20, ated her call light 12 times. On esponse time was between 30 in two incidents the response 40 and 50 minutes. On one ase time was over 100. S dated 9/18/20, included the a diagnosis of multiple uired two staff for toileting and bowel and bladder. Ited 7/3/20, incontinence and own and required staff are plan indicated to keep the and answer promptly. In 9/24/20, at 1:31 p.m. NA-C ally dependent on staff for R13 had to stay in bed for idn't have enough staff to get as when they need her to be. Ite when they nee | 2 800 | | | |

Minnesota Department of Health

| | NT OF DEFICIENCIES NOF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | | 00568 | B. WING | | 09/2 | 28/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | ANT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 800 | medical condition, speriods of time to be In addition, she offet because there is not This was upsetting R13's call light logs reviewed. R13's call light logs reviewed. R13's call oand 20 minutes 20 and 30 minutes 30 and 40 minutes between 40 and 50 between 50 and 60 and over 60 minute R12's quarterly MD R12 had moderate was on hospice ser care. R12's diagnoral disease, asthma/ch disease or chronic failure. R12's medication a report (MAR/TAR), staff, "Connect 02 bedtime." and "Oxy cannula while at remarked as completed 9/17/20. The MAR/has bipap on every cpap placement. Plevery hour overnigl completed on 9/4/2 "Bipap-Nurse must sleeping and at nig completed the night." On 9/24/20, at 3:45 | she often has to wait extended be changed in order to be dry. It is unable to get out of bed on the enough staff to help her up. It to R13. If for 9/8/20 to 9/25/20, was all light response was between on 30 occurrences, between on 15 occurrences, between on seven occurrences, minutes on five occurrences, minutes on 5 occurrences as on four occurrences. Is dated 8/14/20, included, cognitive impairment. R12 roices and required oxygen ses included coronary artery bronic obstructive pulmonary lung disease and respiratory and treatment administration dated August 2020, directed 1.5 L [liters]/min [minute] at a and at night. This was not ted on the night of 9/4/20 and TAR directed "Ensure resident overnight, every night shift for lease ensure Cpap is in place int." This was not marked as | 2 800 | | | |

Minnesota Department of Health

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| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
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| | | 00568 | B. WING | | | 8/2020 |
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| | | | | DEFICIENCY) | | |
| 2 800 | Continued From pa | ge 13 | 2 800 | | | |
| | was "slower" and ' | "needier," than other | | | | |
| | residents. | Tioculor, than other | | | | |
| | On 0/25/20 at 10:20 | a mag family mambar of | | | | |
| | | 9 a.m. a family member of she monitored R12's care | | | | |
| | , | wore a bipap mask at night | | | | |
| | | annula during the day to | | | | |
| | assist with respirate | ory and breathing issues. FM-A | | | | |
| | | R12's bipap or oxygen was | | | | |
| | | 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., | | | | | |
| | | :17 a.m. on 9/24/20. FM-A | | | | |
| | | ese instances, she would call | | | | |
| | | taff, without response. During | | | | |
| | | noted she did not feel well | | | | |
| | | getting the oxygen she | | | | |
| | | as in a "daze". FM-A reported | | | | |
| | | ing both cognitively and | | | | |
| | | more confused when not on tated, on 9/18/20 to 9/19/20 | | | | |
| | | ra activity, indicating no | | | | |
| | | d, in R12's room between | | | | |
| | | 9 p.m. FM-A noted R12 | | | | |
| | | nonitoring to ensure her bipap | | | | |
| | | M-A reported R12 had told her | | | | |
| | | en to staff. FM-A reported she | | | | |
| | | rector of nursing of her | | | | |
| | improvement. | was no resolution or | | | | |
| | improvement. | | | | | |
| | R12's call light log. | dated 9/1/20 to 9/29/20, | | | | |
| | | ated the call light 66 times. | | | | |
| | Eleven of those we | re answered in 10 to 20 | | | | |
| | | answered between 20 to 30 | | | | |
| | | answered between 30 to 40 | | | | |
| | | answered between 40 and 50 | | | | |
| | minutes. Six were a | answered in over 60 minutes | | | | |
| | When interviewed of | on 9/24/20, at 12:23 p.m. | | | | |

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 CA ID PREFEIX TAG PROVIDER OF ALT OF DEFICIENCIES PREFEIX TAG PREFIX TAG PR |
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| NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC 27 BRAND AVENUE FARIBAULT, MN 55021 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 800 Continued From page 14 LPN-A stated there were not enough staff to care center. Residents were not getting the timely care they needed with timely tolleting, 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 there was an overall concern with exident not getting the timely case they was an overall concern with exident not getting the timely assistants duties to help with electronic medical appointments and wound rounds. There was not sufficient nursing assistant dudies 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 |
| SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DEFICIENCY. 2 800 LPN-A stated there were not enough staff to 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 |
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| 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 |

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| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| | | 27 BRAND | AVENUE | | | |
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| 2 800 | Continued From pa | ge 15 | 2 800 | | | |
| | "Short staffing is a completed to the there was nothing to when interviewed a stated there was or residents. Nurses a personal cares for addition to their regwere not able to may were completed. We staffing agency, the they do not have entheir work. LPN-B management and we when interviewed administrator, assist "burned out," becautime to meet reside When interviewed administrator, assist RN-A were interviewed administrator not end wait times, particular "The staff have manoticed "a lot of staffing concerns. The staffing concerns. The staffing concerns. The staffing concerns and cultus staffing concerns. The staff have manoticed to it and chipping in with she felt the communication of the staffing concerns. The staff have was a committed to it and chipping in with she felt the communication of the staffing concerns. The staff have was a committed to it and chipping in with she felt the communication of the staff and | daily occurrence." This had e administrator but was told hey could do about it. on 9/24/20, at 3:45 p.m. LPN-B ne or two aides for 30 were expected to provide to residents each shift in ular duties. Sometimes, they ake sure resident treatments when staff come from a seriough time to complete all of thad reported this concern to was told they had enough staff. on 9/25/20, at 11:12 p.m. on assistance seem to be, use they do not have enough int needs. On 9/28/20, at 3:36 p.m. the stant administrator, DON and wed together. There was no to determine the specific eet resident care planned here should be 1 nursing sidents. DON stated there occupations of the complained about call light arly at night time. RN-A stated, de it seem so drastic" but | | | | |

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census was down.

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| | | FARIBAUL | _T, MN 5502 | 11 | | |
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| 2 800 | Continued From pa | ge 16 | 2 800 | | | |
| | staff, "Our facility postaff with the skills a provide care ad ser accordance with resussessment." and "requirements of directly the needs of the resident's plan of casuages." Suggested the resident's plan of casuages. The fact administrator, DON adequate policy and sufficient staffing based population so reside and timely assistant repositioning, pressussistance. The fact these policies and president care to enscare and services facility could report the quality assurance (QAPI) committee fensure ongoing cortine period to the president care to enscare and services facility could report the quality assurance (QAPI) committee fensure ongoing cortine period the period to the period to the period to the president care to enscare and services facility could report the quality assurance (QAPI) committee fensure ongoing cortine period to the provide the provident period to the period to the provident period to the period t | THOD OF CORRECTION: The or designee could ensure that d programs are developed for ased on the resident ents received safe, adequate ce with toileting, bathing, sure ulcer care, and eating cility could educate staff on perform routine evaluations of sure residents are receiving or adequate staffing. The the findings of these audits to be performance improvement for further recommendations to impliance. R CORRECTION: Twenty-one | | | | |
| 2 830 | MN Rule 4658.0520 Proper Nursing Car | O Subp. 1 Adequate and re; General | 2 830 | | | |
| | receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi | general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a | | | | |

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Minnesota Department of Health

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| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | | he attending physician that the in he in bed or the resident | 2 830 | | | |
| | by: Based on observation review, the facility fassess 3 of 5 reside had fallen, in order prevent further falls for R1 when she suand fractured her stailed to ensure 2 of the state of the falled to ensure 2 of the falled to ens | ent is not met as evidenced ion, interview and document ailed to comprehensively lents (R1, R4, and R3) who to place interventions to a. This resulted in actual harm estained 19 falls, broke a finger kull. In addition, the facility f 5 residents (R10 and R5) ag risk were served the exture diet. | | | | |
| | Findings include: | | | | | |
| | 8/20/20, included, s with diagnoses incl injury) and dementi assistance with mo (ADL's) and did not falls with injury sinc had a discharge MI R1's falls Care Area | a Assessment dated 5/22/20, | | | | |
| | included, "Resident having impaired ba medication use. Refollowing hospitalization infection] and incresinvolved in a MVA [November and suff | triggers for falls r/t [related to] lance and daily psychotropic esident has decreased mobility ation for a UTI [urinary tract ased behaviors. Resident was motor vehicle accident] last fered multiple major injuries hited to: skull fractures, TBI, | | | | |

Minnesota Department of Health

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Minnesota Department of Health

| | ta Department of Tie | | ()(0) 14111 TIDI | F CONSTRUCTION | ()(0) DATE | 01101/61/ |
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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` , | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
| ANDILAN | OF CONTROLL | IDENTIFICATION NOMBER. | A. BUILDING: | | COIVII | LLILD |
| | | | | | C | ; |
| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | ORESS CITY S | STATE, ZIP CODE | | |
| | | 27 BRAND | | | | |
| PLEASA | NT MANOR LLC | | T, MN 5502 | 21 | | |
| 040.15 | CLIMMAN DV CTA | | • | | NA I | ()(5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ge 18 | 2 830 | | | |
| | increased risk for fa agitation, and daily anticonvulsant, anti benzodiazepine me of bowel and bladde history of falls prior any falls since adm to a room closer to Plan to continue to light in reach, and for recommendations." would be addressed R1's admission Fall 5/19/20, included a falls as identified in there was no analysidentification of intereduce the chance R1's care plan date AEB [as evidenced admission related to secondary to TBI and disturbances." The "Resident will be sa should incident occuse one assist for to Place bed on low poor both sides of bed. unless providing ca chair for comfort. To in wheel chair. Pro taking outside and we | dications. She is incontinent er. She does not have a to admission and has not had ission. Resident was moved the nurses station for safety. monitor for safety, keep call ollow therapy The CAA indicated falls d in the care plan. Review Evaluation dated check list of risk factors for the 5/22/20 CAA. However, sis of fall risk factors or rventions that may mitigate or of R1 falling. d 9/2/20, included, "Fall risk by] multiple falls since of lack of safety awareness and Dementia with behavioral goal for R1 was listed as, fe and free from serious injury ur." Staff were directed to, ransfers with a standing lift. Desition. Have fall mats on Leave door open at all times res. Use a tilt-in-space wheel to be visually supervised when vide one on one care, such as wheeling her down the hall. | | | | |
| | identified R1 had fa | ary dated 7/1/20 to 9/28/20, llen 17 times on 7/14/20, | | | | |

Minnesota Department of Health STATE FORM

8/12/20, 8/16/20, 8/16/20, 8/16/20, 8/19/20,

Minnesota Department of Health

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|-----------|----------------------|---|----------------|------------------------------------|-----------|-------------|
| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
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| | | 00568 | B. WING | | | , 8/2020 |
| | | 00300 | | | 0312 | 0/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| DIFAGA | NT MANOR LLO | 27 BRAND | AVENUE | | | |
| PLEASA | NT MANOR LLC | FARIBAUI | _T, MN 5502 | 21 | | |
| (X4) ID | SHMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION |)N | (X5) |
| PREFIX | - | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | | COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPRIES | PRIATE | DATE |
| | | | | DEFICIENCY) | | |
| 2 830 | Continued From pa | nge 19 | 2 830 | | | |
| | • | | | | | |
| | | /3/20, 9/14/20 and 9/15/20. In | | | | |
| | | ress notes dated 7/29/20 and | | | | |
| | | he had fallen, but these were | | | | |
| | | Action Summary. There were | | | | |
| | | or incident reports for the falls | | | | |
| | | tion Summary which were | | | | |
| | | 2/20 (2 falls), 8/19/20, or | | | | |
| | | the falls were identified in the | | | | |
| | | being a fall from bed onto the | | | | |
| | | I. These were on 7/31/20, | | | | |
| | | 6/20 - three times, 8/21/20- 3 | | | | |
| | | 0/20, and 9/3/20. 2 falls were | | | | |
| | | neel chair on 8/29/20 and | | | | |
| | | recliner on 7/29/20. There | | | | |
| | | tion to determine the | | | | |
| | | ne falls that occurred on | | | | |
| | | /11/20, 8/12/20, 8/19/20 or | | | | |
| | 9/14/20. | | | | | |
| | D1's Incident Povic | www.and.Analysis.datad.7/20/20 | | | | |
| | | ew and Analysis dated 7/20/20, bund on the floor on 7/14/20. | | | | |
| | | cluded, "Staff was walking by | | | | |
| | | d saw resident lying on the | | | | |
| | | ith lack of safety awareness | | | | |
| | | o resident's fall risks due to | | | | |
| | | cified TBI w/o loss of | | | | |
| | | mentia with behavioral | | | | |
| | | follow-up/intervention section | | | | |
| | | vear, evaluation by PT/OT | | | | |
| | | ccupational therapy), bed in | | | | |
| | | soft touch call light. Resident | | | | |
| | | vised when in wheelchair. | | | | |
| | | e wheelchair with the ability to | | | | |
| | | en in chair to provide ore | | | | |
| | | riding 1:1 (one on one) care | | | | |
| | | outside and wheeling her | | | | |
| | | sident with behaviors and often | | | | |
| | | . Resident requires 1:1 | | | | |
| | | d to redirect and provide | | | | |
| | | dent is at high fall risk due to | | | | |

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Minnesota Department of Health

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | | 7 t. BOILBII (O. | | | |
| | | 00568 | B. WING | <u> </u> | | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 830 | lack of safety award dementia. Resider and restlessness are sident's self trans to tend to her." The to the care plan. R1's progress note [certified nursing as [10:00 a.m.] that rechair. Upon enterir sitting on the footre recliner was tilting fresident back to se R1's progress note 8:40 PM writer hear room and found resto her bed." Abrasi There was no asse Interventions added resident's bedroom and will keep bathrodark." Keeping the room is dark was no R1's Incident Reviee 8/5/20, identified R: 7/31/20. The reporout of room." No fuwas documented. of notifying the nurs anxiety, agitation, rechange in medication restlessness, and a R1's Incident Reviee R1's Incident R2's Incident | eness due to TBI and at also experiences agitation and could be the reason of aferring to get staff's attention ase interventions were added dated 7/29/20, included, "CNA asistant] told writer at 1000 addent had slid forward in her agroom writer found resident at of her recliner and the forward. Three staff assisted at [sic] of the chair." dated 7/31/20, included, "At ard resident calling out from her addent on the floor laying next ons were noted to both knees. It was ment of this fall. If were, "All staff will make sure door is not closed completely from light on when room is bathroom light on when room is bathroom light on when the ot added to the care plan. It was found on the floor on the identified R1 wanted to, "get urther assessment of this fall however, a new interventions are practitioner of, "frequent estlessness and request a const to decrease anxiety, agitation," was requested. | 2 830 | | | |
| | 8/5/20, identified Roon 8/1/20. The form | 1 had been found on the floor n identified, "Resident wanting This listed the same | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|-------------------------|--|-------------------|--------------------------|
| , | o. oo | | A. BUILDING: | | | |
| | | 00568 | B. WING | · | 09/2 | 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | intervention as the 7/31/20. There was regarding this fall. R1's progress note "Resident found on out. Asked her wha going to the floor." this. R1's progress note included, "Writer not medication aide] at was on the floor." In bed. The note indication offied due to increantianxiety medicates he hurt all over. R1's progress note included, "Aid called had knees on grounded. Resident was facility." | 8/5/20 report for the fall on a no assessment completed dated 8/6/20, included, floor by bed on knees. yelling the she was doing and she said. There was no assessment of dated 8/16/20, at 3:46 p.m. of tified by TMA [trained 1500 [3:00 p.m.] that resident R1 was sitting on floor mat by cated the physician was then eased anxiety and additional in was ordered. R1 indicated dated 8/16/20, at 10:28 p.m. diviter into room. Resident and and torso was still in the confused and wanted to leave dated 8/16/20, at 10:35 p.m. | 2 830 | | | |
| | | d nurse in to find resident arms on the bed. Resident re facility." | | | | |
| | included, "Resident bed. Resident had slid out of her bed. | dated 8/16/20, at 10:40 p.m. was on floor sliding off her just fallen previous to this but Resident was waning [sic] to alling out to staff "someone get | | | | |
| | "Writer observed re | dated 8/21/20, included, esident sitting on floor x 3 on s shift. No injuries noted. Bed | | | | |

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|--|-------------------------|--|-------------------|--------------------------|
| | | | A. BUILDING: | | | , |
| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | nge 22 | 2 830 | | | |
| | at lowest position. | Asked resident what dent stated, "Trying to get out | | | | |
| | 2:15 PM writer hea Writer found reside her W/C [wheel cha Writer found 1" [inc forehead. Residen footwear, foot peda incontinence noted to writer what happ my head." Cool we | dated 8/29/20, included, "At rd resident yelling from lobby. ent laying on the floor next to air] yelling "Ow my head." ch] x 1.5" abrasion to resident's t was wearing appropriate als in place on W/C, and no . Resident unable to describe ened except that "I fell and hit et towel was applied to und an abrasion on her knee | | | | |
| | "Writer heard repeat room and found res bed. Bed was in lo | dated 8/30/20, included, ated yelling out from resident's sident on the floor next to her west position, call light within place both sides of bed, and nent." | | | | |
| | on right index finge There was no incid | dated 8/30/20, noted a bruise or and a scrape on her head. ent report or assessment to ese injuries occurred. | | | | |
| | | dated 8/31/20, included, the updated on bruise to right | | | | |
| | R1's progress note sore right finger." | dated 9/2/20, included, "Ice to | | | | |
| | monitor right index | ord identified staff were to finger related to a fall. identify which fall caused this | | | | |

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Minnesota Department of Health

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | SURVEY PLETED |
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| | | 00568 | B. WING | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | DRESS, CITY, S | TATE, ZIP CODE | | |
| I LLAGA | INT MANOR LLO | FARIBAU | LT, MN 5502 | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ge 23 | 2 830 | | | |
| | "Writer heard reside when writer arrived floor next to her bed up. Bed was in low place and call light." Even though R1 ha there was no composite when the composite in the com | d fallen from bed 13 times, rehensive assessment to | | | | |
| | any pattern in time | on R1 was falling from bed, of day or situation, or to current interventions were not further falls. | | | | |
| | | dated 9/10/20, included, finger related to a fall." "Nail er appears black." | | | | |
| | "Monitor right index "Patients finger con | dated 9//13/20, identified to, finger related to a fall." tinues to be black around the or warmth noted to site. Nail is time." | | | | |
| | 9/15/20, identified F wheelchair on 9/15/ cause of R1's fall fr The form identified | w and Analysis report dated R1 had fallen from her /20. No assessment of the om the chair was completed. R1 was sent to the or evaluation due to a head | | | | |
| | dated 9/15/20, inclufing in bedroom an herself on floor at nagitated/verbally upupstairs." The resu | ssion History and Physical aded, "Patient was found on ad then seemed to throw ursing station. She has been set at times. Wanting to go ults from a CT of head noted ced fracture of the left | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|-------------------------------------|--|---------|--------------------------|
| | | 00568 | B. WING | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | 27 BRANI | DRESS, CITY, S D AVENUE LT, MN 5502 | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 2 830 | posterial parietal be hospital discharge sustained a closed her right hand 2nd fibefore returning to fracture was in a stand happened in the an injury to R1's rigprogress notes on anot assessed by a phospitalized on 9/15. When interviewed on the stated R1 had faller wheel chair, she was and required one of fall. NA-B stated the on ones with R1. Note interventions that he and trying to stand sit with her one on as other residents of the low position and R1 did this she would remembered R1 had area on her forehead but did not know when interviewed of guardian stated the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so when interviewed of the sustaining a fracture undiagnosed for so | one (skull fracture). R1's summary identified R1 had skull fracture and a fracture of inger which would be splinted the nursing home. The finger age of healing, identifying it e past. The facility identified ht index finger in the the 8/30/20. However, this was obysician or x-rayed until 5/20. On 9/24/20, at 1:00 p.m. NA-B in from bed a lot and from her as constantly trying to stand up in one attention or she would ey did not have time to do one IA-B did not know of any elped R1 with the agitation up all the time, other than to one, winch was not possible equired care too. On 9/24/20, at 1:31 p.m. NA-C in frequently, she would herself from bed. The only hew of was to have the bed in a mats on the floor so when aldn't be injured. NA-C in d a large swollen egg sized and had broken her finger, hen this occurred. | 2 830 | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---|---|--------|--------------------------|
| | | 00568 | B. WING | | | 2 8/2020 |
| | PROVIDER OR SUPPLIER | 27 BRAN | DRESS, CITY, S D AVENUE LT, MN 5502 | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 2 830 | constantly throwing threatening to throw was not enough sta supervision with R1 any assessment of determine why she was R1's behaviors assessment of R1's she was, "throwing | herself off the bed and herself off the bed. There off to do one on ones and LPN-A was unable to find R1's falls for pattern or to was falling. LPN-A stated it but was unable to find any behaviors to determine why herself," out of bed. | 2 830 | | | |
| | director of nursing (a good system for ware trying to improve should fill out an Incafter each fall. The of these for R1's fall sustained on 7/14/2 9/15/20. The DON assessment had not other falls R1 sustained and really rewhich they were unwas unable to provide termine if there was unable to provide the | on 9/28/20, at 10:10 a.m. the DON) stated they did not have when someone falls and they e this process. The nurse cident Review and Analysis DON was only able to find 4 ls, which were for the falls 20, 7/31/20, 8/1/20, and did not know why this of been filled out for any of the ined. R1 had behavioral quired one on one attention, able to provided. The DON de any assessment to was a pattern to R1's falls, and may assist R1 with her nat led to her falling so essment had been completed to determine interventions that one may assist R1 with a determine interventions that the maximum process of the provided and the | | | | |

Minnesota Department of Health

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|---|---|------------------------|--|-------------------|--------------------------|
| | | | A. BUILDING. | | | , |
| | | 00568 | B. WING | · | | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 830 | cares 1-3 times dur R3 had 1 fall without assessment. R4's fall CAA includer of the theory of the transfer of hypoglycemic, and psychincontinent of bower ecent fall from bed for safety and keep of the transfer of hypoglycemic, and psychincontinent of bower ecent fall from bed for safety and keep of the transfer of hypoglycemic, and psychincontinent of bower ecent fall from bed for safety and keep R4's care plan daterelated to [blank]. So lowest position. Cal Follow PT and OT if function." The most "Ambulate to dining walker] support with 120 ft [feet] x1 [with was added 7/22/20 been made. R4's nursing assistation assistation of the transfer of | ing the assessment period. | 2 830 | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|------------------------|--|-------|--------------------------|
| | | | A. BOILDING. | | С | |
| | | 00568 | B. WING | | | 28/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEAS# | ANT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | lowest position; roo lit." "Resident recein Seroquel [antipsych agitation/anxiety and following hour. Hose of nursing], and empositive and about in-facility fame ase resident's anxiontact thought it will be a more as the contact thought it wi | m was clear of clutter and well ved PRN [as needed] notic] for increased d was asleep within the pice, ADON [assistant director ergency contact were all emergency contact talked illy visits in hospices [sic] to ciety/agitation and emergency could be worth a try; is going to try and stop for a con 9/28/20, at 10:00 a.m. (N)-A stated there was no cost fall follow-up report on R4's was incorrect about walking neer able to ambulate. In 9/28/20, at 11:35 a.m. I)-B stated they had not been ted to COVID and was 4's falls. FM-B stated R4 o see them out her window for spoken to them about | 2 830 | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---------------------|---|-------|--------------------------|
| | | 00568 | B. WING | | 09/2 | 28/ 2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | T, MN 5502 | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | plan, and communicincreased family viscommunicated to the plan. The facility was plans. R3's admission MD moderate cognitive including a stroke a extensive staff assisted daily living (ADL's), of falls prior to admadmission with no indelusions or hallucing R3's falls CAA date triggers for falls r/t history of falls, and Resident has had a following hospitalizate weakness. He had increased right side OT at this time with community. Resider/t daily antihyperter and hypoglycemic rof bowel and bladder vision, and hearing of falls prior to admission whistomething on the flemonitor for safety, kellow therapy recommunity recommunity recommendates. | cate the change, but the sits had not been he family or added to R4's care has behind in updating care. S dated 8/15/20, included impairment with diagnoses and dementia. R3 required stance with most activities of was unsteady, had a history ission and had fallen since highly. R3 did not have nations. d 8/19/20, included, "Resident having impaired balance, daily antidepressant use. recent decline in mobility ation for increased overall a CVA [stroke] and has weakness. He is in PT and the goal of returning to the ent is at increased risk of falls hisive, psychotropic, diuretic, medications. He is incontinent ter. He has impaired cognitive, Resident does have a history ission and has had one fall tere he was reaching for foor. Plan to continue to seep call light in reach, and mmendations. Care planning | 2 830 | | | |
| | included a checklist before admission, fa use that can increase | valuation dated 8/15/20, of risk factors including fall all after admission, medication se falls, cognition and sensory se, confined to chair, and | | | | |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|-------------------------------|--------------------------|
| | 00568 | B. WING | | 09/2 |) 8/2020 |
| NAME OF PROVIDER OR SUPPLIE | R STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASANT MANOR LLC | | D AVENUE LT, MN 5502 | 1 | | |
| PREFIX (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| findings or indicate factors would be R3's care plan darelated to lack of dementia." R3's and free from fall Answer call light for transfers, followin reach, proper fitems were in reach R3's progress now included, "Writer walked in and say floor. Resident we eating supper. A resident up using Resident states the dropped and he whis wheelchair. From the chair that we have at the medic "Pt [patient] was at the medic "Pt [patient] was a RN heard some shis wheel chair as as we the resident was the resident was called floor. Resident was and had his hand Resident was sitt sitting up. Resident to the resident to the resident was sitt sitting up. Resident was sitt sitting up. Resident was wheel chair to the resident to the resident was sitt sitting up. Resident was sitting up. Resid | ance. There was no analysis of tion on how any of these risk addressed. Ited 8/12/20, included, "Fall risk safety awareness secondary to goal was, "Resident will be safe s." Staff were directed to, promptly, use a mechanical lift to the therapy instructions, call light potwear, ensue frequently used ch. Ite dated 8/10/20, at 9:31 p.m. was called into room when aid we resident laying prone on the ras next to wheelchair and was id, ADON and writer helped hoyer [mechanical] lift. The hat he was eating and his spoon went to go catch it and fell out of the second to the was next to the wheel chair." Ite dated 8/22/20, at 6:55 p.m. was next to the wheel chair." Ite dated 8/22/20, at 6:55 p.m. was next to the room." Ite dated 8/22/20, at 6:55 p.m. was next to the room." Ite dated 8/22/20, at 6:55 p.m. was next adjacent to the room." Ite dated 8/22/20, at 6:55 p.m. was next adjacent to the room." Ite dated 8/22/20, at 6:55 p.m. was next adjacent to the room." Ite dated 8/22/20, at 6:55 p.m. was next adjacent to the room." | 2 830 | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | |
|---|--|--|-------------------------|--|-----------------|--------------------------|
| | | | A. BUILDING: | | С | |
| | | 00568 | B. WING | | _ | 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | 27 BRANI FARIBAUI | O AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ge 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. | | | | | |
| | | | | | | |
| | "Resident was layir Resident was holdi waiving it in the air. right next to him wir Resident states he his room and using out of his way. Reswheelchair while do there were no cats assessment of R3's room, even though | dated 9/11/20, included, ag on back on the ground. In the breaks wheelchair was the the breaks unlocked. It was chasing the cats out of the handle gripper to get them sident then fell out of bing this." "Resident was told in this facility." There was not be belief there were cats in his R3 had not had hallucinations time of the comprehensive | | | | |
| | LPN-C stated other care plan, no new in any of these falls. It any post fall assess The facility had not determine root cause prevent the falls from increased confusion not assessed other which the family definiter disciplinary teament day and place that assessment, b R3. | on 9/28/20, at 10:31 a.m. than what was already in the nterventions were added after LPN-C was unable to provide sment for any of these falls. assessed each fall to se, nor place interventions to m happening again. R3 had after admission, which was than to offer psych services, clined. Normally, the m would assess each fall the new interventions based upon ut this had not been done for | | | | |
| | When interviewed | on 9/28/20, at 11:44 a.m. the | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--------------------------------|-------------------------------|--|
| 00568 | B. WING | | | C 28/2020 | |
| PLEASANT MANOR LLC 27 BRA | ADDRESS, CITY, S' AND AVENUE AULT, MN 5502 | , | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | |
| 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 unab 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-procedure for staff after a resident had sustaine a fall, "staff will monitor and document the resident's response to and the effectiveness of intervention put in place to prevent further falls f72 hours post fall. 2. If resident continues to fall staff will re-evaluate the situation and whether it appropriate to continue or change the current interventions. As needed, the resident's medica provider will assist reconsider possible causes not previously identified. 5. If it is determined an documented that falls may be unavoidable, staff will implement appropriate interventions to prevent serious injury from falls. 6. Care plans where the provider 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 a risk for aspiration of food or fluids. | he le | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 00568 | B. WING | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | 27 BRANI | DRESS, CITY, S D AVENUE LT, MN 5502 | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| 2 830 | (chewing), swallow bite/sip, slow pacing between liquids/soli further analysis wou R10 would be approximately approximately and the rest identified a risk fact diet. No analysis of completed. R10's care plan dat nutritional alteration meals; had diet rest [National Dysphaging ground or are minor pieces, they are mor and could have requirected to monitor, physician as needes wallowing problem. R10's undated nursincluded mechanical meats. Speech themall meats ground, ufor preference." R10's Oral/Dental Eindicated R10 had for During observation was observed to be 12:47 p.m. it was not hamburger patty on hard to eat because | bites before taking another g, single sips, alternate ids. The report indicated ald be required to determine if opriate for diet upgrade. atus CAA dated 4/10/20, for of a mechanically altered if this risk factor was ared 4/1/20, included, risk for a related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be ead no larger than 1/4 inch poist, with some cohesion] diet uested puree. Staff were document, and report to the d for signs and symptoms of | 2 830 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | 00568 | B. WING | | | 2 <mark>8/2020</mark> |
| | PROVIDER OR SUPPLIER | 27 BRANI | DRESS, CITY, S D AVENUE LT, MN 5502 | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 830 | as the staff had grill desired one. R10 ceating, no one check nor did anyone brin. R10's lunch tray tick texture and to provipotato salad, no raviettuce." When interviewed caide (DA)-A stated mechanical soft die with ground meat, she normally does with ground meat, no brocook is the person correct diet is served. When interviewed con the stated R10 does con unaware R10 did not stated if someone is should go get a nur in the dining room. When interviewed con stated if someone is should go get a nur in the dining room. When interviewed con the dining room. | led out the burgers and she continued to cough while cked to see if she was alright, g her dentures. Ket included, "Mechanical soft de ground grilled hamburger, v veggies, beans, shredded on 9/25/20, at 1:06 p.m. dietary residents who require a t should have been provided R10 coughing is something while eating. On 9/25/20, at 1:12 p.m. cook echanical soft diet should have ead or hard vegetables. The responsible to ensure the ed. On 9/25/20, at 1:21 p.m. NA-F ugh at meals, she was of have dentures in. NA-F is coughing like that, they se to assess if no nurse was on 9/25/20, at 1:34 p.m. R10 of gets a ground burger, but whole burger as they were stated she normally wore her at them today. Staff sometimes to put them in or help her with R10 was coughing and NA-H | 2 830 | DEFICIENCY) | | |
| | | on 9/25/20, at 3:06 p.m. RN-B ets could be upgraded if they | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 00568 | B. WING | | 09/2 | 28/ 2020 |
| | PROVIDER OR SUPPLIER | 27 BRAND | | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | wished for an upgrarisk versus benefits a risk versus benefits a risk versus benefits a risk versus benefits he given the risks a regular hamburge. When interviewed of Cook-A stated they who had signed a rifor a diet upgrade, it they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Gronsistency and papureed food if desir. When interviewed or registered dietician coughing during a rithe DON, food servitherapy. This had rifacility should not pidiet without risks be and a form signed. When interviewed of DON and RN-A state correct diet text swallowing problem if a resident is cought. | ade, but would have to sign a statement. R10 did not have its statement signed nor was of choking when provided with er today. In 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the cordered and not a regular indicated R10 was to have a ound Meat NDD2 diet tient could downgrade to ed. In 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to ice director and speech not been done for R10. The rovide an upgraded texture sing explained to the resident with the is important to provide ure for residents with its. A nurse should be notified | 2 830 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 00568 | B. WING | | 09/2 | 28/ 2020 |
| | PROVIDER OR SUPPLIER | 27 BRANI | DRESS, CITY, S D AVENUE LT, MN 5502 | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | stroke, epilepsy. The coughing and choking swallowing medicate period. The MDS for oversite, set up where altered textures. R5's Speech Thera indicated diagnoses and oral phase dyspindicated R5 had more that the evaluation had to denture that did not without dentures, R consistency solids and Advanced. R5 was of materials into the penetration (passage and/or asphyxiation). R5's Care Assessmound dated 1/20/20, indicated 1/20/2 | ne MDS noted R5 had ng during meals or when ions during the assessment of the indicated supervision, en eating and mechanically by Evaluation dated 1/25/19, so of cerebral infarction (stroke) obagia. The evaluation further issing teeth, and at the time of full upper and partial lower of tit. The evaluation indicated 5 could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx,) then the Area Worksheet (CAA) eated R5 required a didiet. There was no analysis a noted to proceed to care different and 3/20/20, indicated R5 was at literation related to chronic didiet restriction for NDD3 cted to monitor, document can for signs or symptoms of | 2 830 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | 00568 | B. WING | | | C 28/2020 | |
| NAME OF PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | TATE, ZIP CODE | | | |
| PLEASANT MANOR LLC | | D AVENUE LT, MN 5502° | 1 | | | |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE | |
| and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticked Dysphagia Advance further directed to phamburger on bun, vegetables, backed lettuce, soft ice created During an observation R5 sat alone at a tall while she ate her more whole hamburger with covered the burger of There were various area including nursing stopped to see why p.m. R5 was observed for someone get and having a seizure. Stoof the dining room. When interviewed of stated R5 should have been ground a potato chips or whole when interviewed of stated she has occasing pells," and has not the word of the dinity or whole when interviewed of cook-A stated the factories. | staff indicated a regular diet dining room which is different AA 1/20/20, Medical Record, care plan. et included a diet order for d diet (NDD3). The tray ticket rovide chopped, grilled potato salad, no raw beans, no bacon, shredded am and milk. on on 9/25/20, at 12:50 p.m. ble and was noted to cough eal. R5's plate contained a ith a wedge of lettuce that on a bun and potato chips. staff throughout the dining ng and dietary, but no one R5 was coughing. At 12:52 red to be shaking and asked hurse because she was aff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A rive received ground meat, soft cooked vegetables. R5 a bun, the burger should and should not have received le leaf lettuce. | 2 830 | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|------------------------|---|--------|--------------------------|
| | | 00568 | B. WING | | | 2 <mark>8/2020</mark> |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 830 | For the noon meal prechanical texture ground hamburger, was the cook's respresident is getting the When interviewed a stated staff should coughing and should have received the who gave her the word who gave her the point of the point of the point of the word word word word word word word word | provided on 9/25/20, a should have included, no bun, potato salad and beans. It consibility to make sure a ne appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are led get a nurse. R5 should correct diet and did not know rong diet. on 9/25/20, at 1:40 p.m. rted both dietary and nursing | 2 830 | | | |

| Minnesota Department of Health | | | | | | |
|--------------------------------|--|---|---------------------|--|------------------------|--------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMPI | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NOWIBER. | A. BUILDING: | | COIVIFI | LETED |
| | | 00568 | B. WING | | C 09/28/2020 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| DIEACA | NT MANOR LLC | 27 BRANI | AVENUE | | | |
| PLEASA | NT MANOR LLC | FARIBAU | LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ge 38 | 2 830 | | | |
| | Level 1 are allowed foods may be groun no larger than one is should be easy to complete Moistened ground of the fish. Moist ground with gravy or sauce pureed bread mixed and slurred breads thickness of products. Vegetables vegetables. Vegetables | ically Altered. All foods on . Meats and other select and or minced into small pieces forth inch. All food items shew. Meats should be or cooked meat, poultry, or or tender meat may be served . Breads products can be s, moistened bread crumbs that are gelled through entire et and to avoid all other bread es should be soft, well-cooked ables should be less than 1/2 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 FOF (21) days. | R CORRECTION: Twenty-one | | | | |
| 2 905 | MN Rule 4658.0525 | 5 Subp. 4 Rehab - Positioning | 2 905 | | | |
| | positioned in good lof residents unable | g. Residents must be body alignment. The position to change their own position t least every two hours, | | | | |

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| | | 00568 | B. WING | | C 09/28/2020 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | 27 BRAND | _ | | | |
| | | | T, MN 5502 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 905 | Continued From pa | ge 39 | 2 905 | | | |
| | been put to bed for has documented the hours during this tin | time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or rdered a different interval. | | | | |
| | 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. | | | | | |
| | (CAA) dated 8/28/2 for pressure r/t [relawith bed mobility an incontinence. Residdown r/t cognitive in HTN [hypertension] and daily use of AS [blood thinner]. She bladder. Resident nover skin tear on LL otherwise intact. Proplace with toileting a hours, pressure red wheelchair and mat | Care Area Assessment 0 included, "Resident triggers ated to] need for assistance and bowel and bladder lent is at risk for skin break inpairment, dx [diagnosis] of and Type 2 DM [diabetes] A [aspirin] and Coumadin is incontinent of bowel and intended to have scabbed area LE [lower left extremity]. Skin eventative skin measures in and repositioning q [every] 2 listribution cushion to tress to bed, routine skin [morning] and HS [night], and | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|-------------------------|--|-------------------------------|--------------------------|--|
| | | | A. BUILDING: | | | С | |
| | | 00568 | B. WING | | | 09/28/2020 | |
| NAME OF PROVIDER OR SUI | PPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| PLEASANT MANOR LL | С | | D AVENUE LT, MN 5502 | 21 | | | |
| PREFIX (EACH DEF | ICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| alteration in s "Monitor skin inspection by order. Pressur Pressure red chair." Care p R4's care pla mobility relate "Dependent v staff]. Maxi lif transfers. Tur hours]." Addir "Alteration in 9/8/20: "Posit [as needed] v R4's nursing "Assist of 2 w not ambulate on how often repositioning. A Hospice Fa 9/3/20 include to bottom." During contin starting at 10 herself in the effectively ad members ask R4 verbally d offered to red declined. No provided. No occurred. At | n dates kin integral nurse integral nurse istriburblan in nurse with bed to ewith bed to and tionally assistant to assista | | 2 905 | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | DATE SURVEY COMPLETED | |
|---|---|--|------------------------|--|--------------------------|------------------|
| | | | A. BOILDING. | | С | |
| | | 00568 | B. WING | | _ | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 24 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECT | ION | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | COMPLETE DATE |
| 2 905 | Continued From pa | ge 41 | 2 905 | | | |
| | repositioned. LPN-I room. At 1:55 p.m. NA-B assisted R4 in bed using 2 pillows stated, "Oh God, th pain was in her back." When interviewed and NA-B stated the morning cares at 7: not had time to ass since getting her up. "There are only two best, it is terrible." we can't get to her, NA-B acknowledge the same position in | er insulin. R4 was not D brought R4 to the dining nursing assistant (NA)-F and nto bed and positioned her in . As R4 was laid in bed she at hurts." R4 specified that the ek. on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 1:30 a.m. NA-F stated they had ist R4 to lie down or reposition of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours in the chair without being hould be repositioned every 2 | | | | |
| | | on 9/28/20, at 3:05 p.m. the (DON) stated R4 should be 2 hours. | | | | |
| | 5/2013) identified, " resident who is imm for repositioning." T "Residents who are every 1 hour (q1 ho Residents who are an every 2 hour (q2 schedule." Facility p Wound Manageme identified "A weekly completed by licens | | | | | |
| | SUGGESTED MET | HOD OF CORRECTION: | | | | |

6899

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|-------------------------|--|------------------------|--------------------------|
| | | 00500 | B. WING | | C 09/28/2020 | |
| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 905 | The director of nurs all residents at risk they are receiving the treatment/services from developing an pressure ulcers. The designee, could condelivery of care; to deservices are implended pressure ulcer developments are ulcer developments. Time period for the pressure ulcer developments are implended for the pressure ulcer developments. | sing or designee, could review for pressure ulcers to assure the necessary repositioning to prevent pressure ulcers do to promote healing of the director of nursing or induct random audits of the tensure appropriate care and the netted; to reduce the risk for elopment. | 2 905 | | | |
| 2 920 | Subp. 6. Activities comprehensive reshome must ensure B. a resident who activities of daily living services to maintain and personal and o | is unable to carry out ing receives the necessary in good nutrition, grooming, | 2 920 | | | |
| | by: Based on observati review, the facility facare timely, and fail status after a signifi residents (R3) revie Findings include: R4's admission Min 6/29/20, included, n with diagnoses includes | on, interview, and document ailed to provide incontinence ed to reassess continence cant change for 1 of 3 ewed for incontinence. imum Data Set (MDS) dated noderate cognitive impairment uding diabetes, dementia and ed extensive assistance with | | | | |

6899

Minnesota Department of Health

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|----------------------------|--|-------------------------------|--------------------------|
| | | | A. BUILDING: | | С | |
| | | 00568 | B. WING | | | 8/2020 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 920 | hygiene. R4 was n was occasionally in times during the as R4's incontinence of dated 7/1/20 indicar urinary incontinence assistance with tolk incontinence." "She and OT [occupation the goal of returning uses incontinence of dry. Plan to continuand complete perioders. Plan to continuand complete perioders included severe condependent upon standard hygiene and was al R4's incontinence of "Resident triggers of toilet use and bladed declined in both months as recently endified as recently endified as recently endified in keeping skin current toileting plate [every] AM [morning incontinent episoders] R4's only Bowel and medical record was R4 was continent on R4's care plan dates. | assistance with personal of on a toileting program and continent of urine (less than 7 sessment period). Care Area Assessment (CAA) ted, "Resident triggers for e r/t [related to] need for et use and bladder is in PT [physical therapy] and therapy] at this time with ground to the community. Resident products to aid in keeping skin e to with current toileting plan cares q [every] AM [morning], a each incontinent episode." Inge MDS dated 8/27/20, gnitive impairment, was totally aff for toileting and personal ways incontinent of urine. CAA dated 8/28/20 included, for urinary incontinence r/t ler incontinence. Resident has obility and cognitive function. Incolled in hospice for end of a uses incontinence products to dry. Plan to continue to with and complete peri cares q g], HS [night], and with each incolled and bladder. In Bladder assessment in the stated 6/24/20, and indicated from the ladder. In Bladder assessment in the stated 6/26/20, included, and bladder. In Bladder assessment in the stated 6/26/20, included, and bladder. | 2 920 | | | |
| | | nination." Staff were directed toileting." The care plan had | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLI A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|-------------------------------|--|-------------------------------|--------------------------|
| , | 00568 | B. WING | | 09/2 | 28/2020 |
| NAME OF PROVIDER OR SUPPLIER | | , , | TATE, ZIP CODE | • | |
| PLEASANT MANOR LLC | 27 BRAND FARIBAUL | AVENUE T, MN 5502 | 1 | | |
| (X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDEN | BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 2 920 Continued From page 44 not been updated since 6/8/27/20, MDS noted a decincontinence to totally incomin assistance needs for to hygiene. R4's nursing assistant Ca "Assist of 2 w/ Hoyer [medambulate." No information nursing assistants on how toileting needs. During continuous observes starting at 10:34 a.m. 2 striff she would like to lay down declined. No encouragem provided. No additional at incontinence cares occurred licensed practical nurse (Inherican the proof to check blood sinsulin. LPN-D then brough room. Incontinence cares 1:58 p.m. NA-F and NA-B and changed R4's visibly with When interviewed on 9/25 and NA-B stated they had morning cares at 7:30 a.m. not had time to assist R4 since getting her up at 7:30 "There are only two of us best, it is terrible." NA-B swe can't get to her, we show NA-B acknowledged R4 he without being assisted with in the same control of the proof of | cline in urinary continent and an increase dileting and personal are Sheet included, chanical lift]; does not in was included to direct or to attend to R4's action on 9/25/20, aff members asked R4 on. R4 verbally dent or re-approach was tempts to provide and administer of the R4 to the dining are not provided. At assisted R4 into bed wet brief. 5/20, at 2:05 p.m. NA-F assisted R4 with a subject of the R4 with a subje | 2 920 | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|-------------------------|--|------------------------|--------------------------|
| | | 00568 | B. WING | | C 09/28/2020 | |
| NAME OF | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | D AVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 920 | needs very well. Rowas present review and Bladder assess 6/24/20, noting it incidentified R4 had not bladder. RN-A review identified R4 had not bladder assessmer significant decline in June of 2020. RN-A an updated assessichange MDS compexplained they were R4 was on their worshould have been of changed at least event and the state of the facility policy To 11/2019) identified, incontinence production and care planning (revision care plan is to be modition and care of changes." SUGGESTED MET The director of nurs review and revise presponsible staff to dependant on facility comprehensively as designee could con resident cares to er needs are met time. | egistered nurse (RN)-A who wed R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and of had an updated Bowel and an condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A be behind on assessments and rk list, "to be caught up." R4 shecked for incontinence and ery 2 hours. Dileting Assistance (policy date "If a client wears an ct, check if soiled or wet and "The facility policy Care date 6/2019) identified "The medified and updated as the needs of the resident HOD OF CORRECTION: sing and/or designee could rocedures and educate provide care to residents' by staff, based on residents' sy staff, based on residents' ssessed needs. The DON or duct audits of dependent asure their personal care | 2 920 | | | |

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | , , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|------------------------|--|-------------------------------|--------------------------|
| | | | | | С | |
| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| PLEASA | NT MANOR LLC | | DAVENUE LT, MN 5502 | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21810 | Continued From pa | ge 46 | 21810 | | | |
| 21810 | MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights | | 21810 | | | |
| | residents shall have medical and persor needs. Appropriate care designed to er highest level of phy This right is limited | riate health care. Patients and eithe right to appropriate hal care based on individual ecare for residents means hable residents to achieve their sical and mental functioning, where the service is not blic 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: | | | | | |
| | 7/28/20, included m with a diagnosis of incontinent and req | nimum Date Set (MDS) dated noderate cognitive impairment a stroke. R7 was occasionally uired assistance by one staff on and off of the toilet. | | | | |
| | Rehab Care Assess dated 9/25/20, includecline in mobility, | of daily living)/Functional sment Area Worksheet (CAA) ided, R7 has had a recent was occasionally incontinent er, and needed assistance for est. | | | | |
| | required assistance dependent assist, d | d 7/29/20, included, R7 for, "Bathing with max to dressing with max assist, et-up with minimal assist. | | | | |

Minnesota Department of Health

STATE FORM 2XHN11 If continuation sheet 47 of 49

Minnesota Department of Health

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------------------------|--|-------------------------------|--------------------------|
| | | | · · · · · · · · · · · · · · · · · · · | | С | |
| | | 00568 | B. WING | | 09/2 | 8/2020 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | STATE, ZIP CODE | | |
| PLEASA | PLEASANT MANOR LLC 27 BRANI FARIBAU | | | 21 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21810 | Continued From pa | ge 47 | 21810 | | | |
| | occasionally incontinent, and requires assistance with toilet use." | | | | | |
| | was lying in bed. Refacility is very bad. It there seems to be refacility. Call lights can hour. I push the call bathroom and no or wet myself. I feel he chair and embarrass cleaned up and chabrow was furled and R7 stated this happ. When interviewed conursing assistant (New wait for assistance her incontinent. This Most residents wait time to receive an a has assisted R7 aft secondary to waiting time for the call light that there have been beginning of the shis soiled and need assinght shift is custom one licensed praction nurse (RN) for the affacility. When interviewed of LPN-D state there is individual needs of among staff and residents. | on 9/25/20, at 2:00 p.m. R7 7 stated, "Staffing for the I blame the State because to staffing guidelines for this an go unanswered for over an I light when I need to go to the ne comes until it is too late. I umiliated about wetting in the sed about needing to be anged." R7 looked angry, her did her face became slightly rediens at least once a week. On 9/25/20, at 2:35 p.m. JA)-D stated R7's often has to to the bathroom which makes is was always upsetting to R7. For an extended period of answer to their call light. NA-D er R7 was incontinent gror a prolonged period of to be answered. NA-D stated in, "too many times," at the lift when several residents are sistance. NA-D stated the narily staffed with two NA's and cal nurse (LPN) or registered the control of the staff to meet the each resident. The morale sidents is low because of this. In the due to not being able to get gonity issue. | | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|-------------------------------------|--|-------------------------------|--------------------------|
| | | 00568 | B. WING | | 09/2 | 8/2020 |
| | PROVIDER OR SUPPLIER | 27 BRAN | DRESS, CITY, S D AVENUE LT, MN 5502 | STATE, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21810 | 9/22/20, at 3:51 a.n showed the call lighthe seven day periodinitiated, 11 (or 21.5 15 minutes to receit 14%) of these alerts to receive a responsible. During a phone call p.m. the administrastaffing or facility as determining staffing administrator stated include one staff me "More comradery a was needed among would improve care they are working or SUGGESTED MET. The administrator, of designee could revien sure residents retimely fashion. It coresidents that may | nse time logs dated from n. to 9/28/20, 9:25 a.m. It was engaged 51 times over Id. Of the 51 call light alerts Id. Of these alerts took over Id. of these alerts Id. of these Id. of thes | 21810 | | | |
| | changes, and audit needs of resident(s audits for an amour quality assessment improvement (QAP compliance. The ad | I) committee could ensure Iministrator, DON, or designee t information back to QAPI to | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |

PRINTED: 10/13/2020 FORM APPROVED OMB NO. 0938-0391

| 245090 NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--|--------|---|--------|------------|
| NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE PRESIDENT, MN 55021 PROVIDER SUMMARY STATEMENT OF DEPOCINCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD 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 F677 and F725 H5090099C at F677 and F725 The following complaints were found to be unsubstantiated: H5090055C and H5090056C. 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 550 Resident Rights/Exercise of Rights CFR(s). 483.10(a)(1)(2)(b)(1)(2) S483.10(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 | | | 245090 | | | | |
| FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 complaines. The following complaints were found to be substantiated: H5090055C at F689 H509005FC at F687, 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 your verification. F 550 Resident Rights/Exercise of Rights SS=D CFR(s): 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 binses specified in | | | | | 27 BRAND AVENUE | 1 09/2 | 20/2020 |
| 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: H509005FC at F689 H509005FC at F677 and F725 H509005FC at F677, F686 and F725 The following complaints were found to be unsubstantiated: H5090055C and H509005BC. 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 550 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 | PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP |) BE | COMPLETION |
| SS=D 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 | | On 9/24/20, 9/25/2 survey was comple complaint investiga not to be in complia Requirements for L. The following comp substantiated: H5090056C at F67/H5090059C at He bottom of the form. Your electronia be used as verificat Upon receipt of an inon-site revisit of you validate that substate gulations has been your verification. | 0 and 9/28/20, an abbreviated ted at your facility to conduct a tion. Your facility was found ince with 42 CFR Part 483, ong Term Care Facilities. Ilaints were found to be 77 and F725 77, F686 and F725 Ilaints were found to be 5090055C and H5090058C. If correction (POC) will serve for compliance upon the otance. Because you are rour signature is not required a first page of the CMS-2567 to submission of the POC will tion of compliance. acceptable electronic POC, an air facility may be conducted to intial compliance with the en attained in accordance with | | | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE | SS=D | CFR(s): 483.10(a)(§483.10(a) Resider The resident has a self-determination, access to persons a outside the facility, this section. | 1)(2)(b)(1)(2) It Rights. It | | | | (VO) DATE |

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

(X6) DATE

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | PLE CONSTRUCTION IG | CON | (X3) DATE SURVEY COMPLETED | |
|--|---|--|----------------------|--|-------------------------------|----------------------------|
| | | 245090 | B. WING _ | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP O 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 550 | with respect and digresident in a manner promotes maintenather quality of life, reindividuality. The fapromote the rights of \$483.10(a)(2) The access to quality caseverity of condition must establish and practices regarding provision of service residents regardles §483.10(b) Exercise The resident has the rights as a resident or resident of the U §483.10(b)(1) The free interference, coercifrom the facility. §483.10(b)(2) The free of interference reprisal from the facility. §483.10(b)(2) The free of interference reprisal from the facility. This REQUIREMENT by: Based on observative review, the facility for t | cility must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and of the resident. Facility must provide equal are regardless of diagnosis, in, or payment source. A facility maintain identical policies and transfer, discharge, and the is under the State plan for all is of payment source. The of Rights is eright to exercise his or her of the facility and as a citizen inted States. The coefficient has the right to be in coercion, discrimination, or reprisal in exercising his or her ported by the facility in the er rights as required under this interview, and document ailed to provide care in a ted dignity for 1 of 1 resident in the eright of the second in a ted dignity for 1 of 1 resident in a ted dignity for 1 of | F 55 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | |
|--|---|--|---------------------|--|------------------------------|----------------------------|--|
| | | 245090 | B. WING _ | | | 28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 550 | 7/28/20, included myith a diagnosis of incontinent and requesson to transfer of R7's ADL (activities Rehab Care Asses dated 9/25/20, includedine in mobility, of bowel and bladd toileting upon requested assistance dependent assist, of personal hygiene's occasionally incontwith toilet use." When Interviewed was lying in bed. R facility is very bad. there seems to be facility. Call lights of hour. I push the call bathroom and no of wet myself. I feel in chair and embarras cleaned up and chabrow was furled an R7 stated this happy. | nimum Date Set (MDS) dated noderate cognitive impairment a stroke. R7 was occasionally quired assistance by one staff on and off of the toilet. s of daily living)/Functional sment Area Worksheet (CAA) uded, R7 has had a recent was occasionally incontinent er, and needed assistance for | F 55 | | | | |
| | wait for assistance | to the bathroom which makes is was always upsetting to R7. | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---------------------|---|-------------------------------|----------------------------|
| | | 245090 | B. WING _ | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 550 | time to receive an a has assisted R7 af secondary to waiting time for the call light that there have been beginning of the shooled and need as night shift is custor one licensed practinurse (RN) for the facility. When interviewed LPN-D state there individual needs of among staff and re R7 being incontine to her timely is a direct to receive a responsible to receive a | t for an extended period of answer to their call light. NA-D ter R7 was incontinent ag for a prolonged period of ant to be answered. NA-D stated en, "too many times," at the aft when several residents are asistance. NA-D stated the marily staffed with two NA's and acal nurse (LPN) or registered 42 current residents in the cach resident. The morale asidents is low because of this. In the due to not being able to get gnity issue. Onse time logs dated from and to 9/28/20, 9:25 a.m. In the was engaged 51 times over and. Of the 51 call light alerts 5%) of these alerts took over the aresponse. Seven (or the stook longer than 20 minutes assessment in place to assist in geneds at this time. The discurrent staffing rations are medical. These measures and better communication," gethe staff. These measures as The administrator stated that | F 58 | 50 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---------------------|--|--------------------------------|----------------------------|
| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIF 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 120/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| | CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d) (1) Notice nursing facility trans the resident goes of nursing facility must the resident or resid specifies- (i) The duration of the any, during which the return and resume of facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing face bed-hold periods, we paragraph (e)(1) of resident to return; and (iv) The information of this section. §483.15(d)(2) Bed- the time of transfer hospitalization or the facility must provide resident representate specifies the duration described in paragr This REQUIREMEN by: Based on document facility failed to issue | of bed-hold policy and returnate before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the trovide written information to dent representative that the state bed-hold policy, if he resident is permitted to residence in the nursing a payment policy in the state of this chapter, if any; ility's policies regarding which must be consistent with this section, permitting a land a specified in paragraph (e)(1) thold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section. Note that the section of the properties of the review and interview, the end written bed-hold notice thospital for 1 of 3 residents | F 6 | 25 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION NG | COM | MPLETED |
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| | | 245090 | B. WING | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | 20/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 625 | R1's admission Min 5/20/20, indicated F 5/14/20 with a dischanticipated MDS da R1's progress note included, R1 was tr full report was given teams. However a lin R1's medical recommendation when interviewed a guardian reported shed hold notification possibility to hold the When interviewed a interim director of new formatical statements. | imum Data Set (MDS) dated R1 was admitted to facility on harge assessment-return ated, 9/16/20. dated 9/16/20, at 6:24 p.m. ansferred to the hospital and a not the police and transport ped hold notice was not found ord. on 9/24/20, at 3:07 p.m. R1's the had not been provided a not and was unaware of the | F 6 | 25 | | |
| F 677 SS=D | Emergency revised bullet number 4: "Ti responsible for: b. or her representative readmission appearect." ADL Care Provided CFR(s): 483.24(a)(2) §483.24(a)(2) A responsible services to maintain personal and oral harmonic transportation of the services to maintain personal and oral harmonic transport to the services to maintain personal and oral harmonic transport to the services to maintain personal and oral harmonic transport to the services to maintain personal and oral harmonic transport to the services to maintain personal and oral harmonic transport to the services to the servic | ident who is unable to carry y living receives the necessary n good nutrition, grooming, and | F 6 | 77 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 120/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE LE APPROPRIATE | (X5) COMPLETION DATE |
| F 677 | status after a signif residents (R3) revies Findings include: R4's admission Min 6/29/20, included, rwith diagnoses included thygiene. R4 requires toileting and limited hygiene. R4 was nwas occasionally in times during the as R4's incontinence of dated 7/1/20 indicatorinary incontinence assistance with toile incontinence." "She and OT [occupation the goal of returning uses incontinence of dry. Plan to continuand complete perioders included severe condependent upon states incontinence of the properties of the goal of | ed to reassess continence cant change for 1 of 3 ewed for incontinence. imum Data Set (MDS) dated noderate cognitive impairment uding diabetes, dementia and ed extensive assistance with assistance with personal of on a toileting program and continent of urine (less than 7 sessment period). Care Area Assessment (CAA) ted, "Resident triggers for er/t [related to] need for | | 677 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING _ | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COE 27 BRAND AVENUE FARIBAULT, MN 55021 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 677 | [every] AM [mornin incontinent episode R4's only Bowel and medical record was R4 was continent of R4's care plan date "Alteration with elinato, "Assist of 1 with not been updated as 8/27/20, MDS note incontinence to total in assistance need hygiene. R4's nursing assist "Assist of 2 w/ Hoy ambulate." No information assistants tolleting needs. During continuous starting at 10:34 a. if she would like to declined. No encouprovided. No additincontinence cares licensed practical rher room to check insulin. LPN-D ther room. Incontinence 1:58 p.m. NA-F and and changed R4's | in and complete peri cares q g], HS [night], and with each g." Id Bladder assessment in the stated 6/24/20, and indicated of bowel and bladder. Id 6/26/20, included, inination." Staff were directed a toileting." The care plan had since 6/26/20, even though the dadecline in urinary ally incontinent and an increase is for toileting and personal I ant Care Sheet included, er [mechanical lift]; does not formation was included to direct for how to attend to R4's Observation on 9/25/20, m. 2 staff members asked R4 lay down. R4 verbally uragement or re-approach was onal attempts to provide occurred. At 11:46 a.m. hurse (LPN)-D brought R4 to blood sugar and administer in brought R4 to the dining er cares were not provided. At di NA-B assisted R4 into bed | F 67 | 77 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | IPLE CONSTRUCTION NG | CON | (X3) DATE SURVEY COMPLETED | |
|--|--|---|-----------------------|---|-------------------------------|----------------------------|
| | | 245090 | B. WING _ | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | 20,2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 677 | since getting her up "There are only two best, it is terrible." we can't get to her, NA-B acknowledge without being assist When interviewed of director of nursing (should be assisted hours. The DON staneeds very well. Rowas present review and Bladder assess 6/24/20, noting it in bladder. RN-A revisidentified R4 had not Bladder assessmer significant decline in June of 2020. RN-an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least extended the stane of t | ist R4 to lie down or toilet of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. on 9/28/20, at 3:05 p.m. the DON) stated, she thought R4 with incontinent cares every 2 rated she did not know R4's registered nurse (RN)-A who wed R4's most recent Bowel sment, which was dated dicated R4 was continent of rewed R4's medical record and of had an updated Bowel and an condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A re behind on assessments and rk list, "to be caught up." R4 shecked for incontinence and | F 67 | | | |
| | CFR(s): 483.25(b)(| | 1 00 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 686 | resident, the facility (i) A resident receive professional stand pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with necessary treatment with professional sepromote healing, promote h | tegrity source ulcers. Drehensive assessment of a y must ensure that- yes care, consistent with ards of practice, to prevent d does not develop pressure individual's clinical condition they were unavoidable; and pressure ulcers receives int and services, consistent tandards of practice, to revent infection and prevent eveloping. NT is not met as evidenced tion, interview, and document failed to provide repositioning sidents (R4) reviewed who eloping pressure ulcers. ange Minimum Data Set (MDS) uded severe cognitive diagnosis of dementia. R4 assist for bed mobility and be for transfer. R4 was at risk development, but did not have | F 68 | 6 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | ONSTRUCTION | | COM | E SURVEY PLETED |
|--------------------------|--|---|---------------------|--------------|---|--------|------|----------------------------|
| | | 245090 | B. WING | | | | 09/2 | 28/2020 |
| | PROVIDER OR SUPPLIER | | | STRE 27 B | EET ADDRESS, CITY, STATE, ZIP CODE RAND AVENUE RIBAULT, MN 55021 | | | 10/1010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD B | | (X5) COMPLETION DATE |
| F 686 | [blood thinner]. She bladder. Resident nover skin tear on LI otherwise intact. Preplace with toileting a hours, pressure recomplete wheelchair and matcares q [every] AM weekly skin inspect. R4's care plan date alteration in skin into "Monitor skin integrinspection by nurse order. Pressure redistribution of the pressure redistribution of t | A [aspirin] and Coumadin is incontinent of bowel and oted to have scabbed area LE [lower left extremity]. Skin eventative skin measures in and repositioning q [every] 2 listribution cushion to stress to bed, routine skin [morning] and HS [night], and ions." d 6/26/20 included, "Potential egrity." Staff were directed to, ity daily. Weekly skin . Treatment to open areas per istribution mattress to bed. tion cushion to wheelchair, terventions updated 9/1/20. er indicated, "Alteration in and of life" with interventions: d mobility: A1-2 [assist of 1-2 er) [mechanical lift] with reposition Q2H [every 2 of R4's care plan specified, ort," with an intervention dated hrs [every 2 hours] and PRN | F6 | 86 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|--------------------|--|-------------------------------|----------------------------|--|
| | 245090 | | B. WING | | | C 09/28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP O 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 720,2020 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE | (X5) COMPLETION DATE | |
| F 686 | starting at 10:25 a.r herself in the wheel effectively adjust he members asked R4 R4 verbally declined offered to recline R declined. No encouprovided. No addition occurred. At 11:46 at (LPN)-D brought R4 sugar and administ repositioned. LPN-I room. At 1:55 p.m. NA-B assisted R4 in bed using 2 pillows stated, "Oh God, the pain was in her back." When interviewed and NA-B stated the morning cares at 7: not had time to assince getting her up. "There are only two best, it is terrible." we can't get to her, NA-B acknowledge the same position in repositioned. R4 shours. When interviewed addirector of nursing (repositioned every in the facility policy R5/2013) identified, "resident who is immediate resident who is immediate to recipie the recipie the recipie to recipie the recipie to recipie the recipie the recipie to recipie the recipie to recipie the recipie to recipie the recipie to recipie the recipie the recipie to recipie the recipie the recipie to recipie the recipie the recipie the recipie to recipie the recipie to recipie the recipie to recipie the recipie to recipie the re | m. R4 was attempting to adjust chair, but was not able to erself. At 10:34 a.m. 2 staff if she would like to lay down. d. The 2 staff members 4's wheelchair. R4 verbally ragement or re-approach was onal attempts to reposition a.m. licensed practical nurse 4 to her room to check blood er insulin. R4 was not 0 brought R4 to the dining nursing assistant (NA)-F and not bed and positioned her in . As R4 was laid in bed she at hurts." R4 specified that the ek. on 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or reposition of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours in the chair without being hould be repositioned every 2 on 9/28/20, at 3:05 p.m. the (DON) stated R4 should be | F 6 | 686 | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) M A. BUI | ILDING | (X3) DATE SURVEY COMPLETED | |
|---|---|----------------------------|--|
| 245090 B. WII | NG | C 09/28/2020 | |
| NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | 1 33/23/2020 | |
| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI | D PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD AG CROSS-REFERENCED TO THE APPROFILIENCY) | D BE COMPLÉTION | |
| "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." | = 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | TIPLE CONSTRUCTION | COM | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--------------------|--|-------------------------------|----------------------------|--|
| | | 245090 | B. WING | | | C 09/28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 120/2020 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 689 | assistance with mo (ADL's) and did not falls with injury sinchad a discharge MI R1's falls Care Area included, "Resident having impaired ba medication use. Refollowing hospitalization infection] and increasinvolved in a MVA [INOVEMBER and Suffincluding but not limit fractures, and wincreased risk for fat agitation, and daily anticonvulsant, antibenzodiazepine me of bowel and bladd history of falls prior any falls since adm to a room closer to Plan to continue to light in reach, and for recommendations." would be addressed R1's admission Fall 5/19/20, included a falls as identified in there was no analysidentification of intereduce the chance R1's care plan date | ambulate. R4 had 2 or more e the prior assessment. R1 DS dated 9/16/20. Assessment dated 5/22/20, triggers for falls r/t [related to] lance and daily psychotropic esident has decreased mobility ation for a UTI [urinary tract ased behaviors. Resident was motor vehicle accident] last ered multiple major injuries nited to: skull fractures, TBI, rist fractures." "Resident is at alls r/t cognitive impairment, use of psychotropic, hypertensive, and edications. She is incontinent er. She does not have a to admission and has not had dission. Resident was moved the nurses station for safety. monitor for safety, keep call collow therapy The CAA indicated falls d in the care plan. Review Evaluation dated check list of risk factors for the 5/22/20 CAA. However, sis of fall risk factors or rventions that may mitigate or of R1 falling. | F6 | 889 | | | |
| | admission related to | by] multiple falls since o lack of safety awareness nd Dementia with behavioral | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|---|-------------------------------|----------------------------|
| | | 245090 | B. WING | | Uc | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 720720 |
| (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 CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 689 | "Resident will be sa should incident occuse one assist for the Place bed on low poth sides of bed. Unless providing cachair for comfort. In wheel chair. Protaking outside and R1's Action Summa identified R1 had fa 7/31/20, 8/12/20, 8/12/20, 8/12/20, 8/12/20, 8/21/20, 8/21/20, 8/29/20, 9/20/20, 9/20/20/20/20/20/20/20/20/20/20/20/20/20/ | age 14 agoal for R1 was listed as, afe and free from serious injury sur." Staff were directed to, transfers with a standing lift. osition. Have fall mats on Leave door open at all times ares. Use a tilt-in-space wheel to be visually supervised when wide one on one care, such as wheeling her down the hall. ary dated 7/1/20 to 9/28/20, allen 17 times on 7/14/20, 8/20, 8/6/20, 8/11/20, 8/12/20, 8/6/20, 8/16/20, 8/11/20, 8/12/20, 8/6/20, 8/16/20, 8/19/20. In the second fallen, but these were action Summary. There were or incident reports for the falls tion Summary which were action Summary which were a falls were identified in the being a fall from bed onto the defining a fall from bed onto the defining and 9/3/20. 2 falls were neel chair on 8/29/20 and a recliner on 7/29/20. There tion to determine the falls that occurred on 8/11/20, 8/12/20, 8/19/20 or and Analysis dated 7/20/20, outlood, "Staff was walking by disaw resident lying on the aith lack of safety awareness | F 6 | 89 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | TIPLE CONSTRUCTION ING | COM | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|------------------------|--|-------------------------------|----------------------------|--|
| | | 245090 | B. WING | | C 09/28/2020 | | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP OF 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 120/2020 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 689 | which contributes to diagnosis of unspec consciousness; Ded disturbance." The filisted: proper footw (physical therapy/or lowest position and to be visually super Provide tilt-in-space recline resident who comfort. Staff provide staking her down the hall. "Resident and restlessness are sident's self transito tend to her." The tothe care plan. R1's progress note [certified nursing as [10:00 a.m.] that reschair. Upon entering sitting on the footre recliner was tilting fresident back to sear the self-under the se | resident's fall risks due to cified TBI w/o loss of mentia with behavioral follow-up/intervention section wear, evaluation by PT/OT occupational therapy), bed in soft touch call light. Resident vised when in wheelchair. Wheelchair with the ability to en in chair to provide ore iding 1:1 (one on one) care outside and wheeling her sident with behaviors and often Resident requires 1:1 do to redirect and provide dent is at high fall risk due to eness due to TBI and the also experiences agitation and could be the reason of ferring to get staff's attention ese interventions were added dated 7/29/20, included, "CNA esistant] told writer at 1000 sident had slid forward in her agroom writer found resident st of her recliner and the orward. Three staff assisted at [sic] of the chair." dated 7/31/20, included, "At or resident calling out from her sident on the floor laying next ons were noted to both knees. | F6 | 689 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
|--|--|---|---------------------|---|------------------------------|----------------------------|
| | | 245090 | B. WING _ | | | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 689 | room is dark was n R1's Incident Revie 8/5/20, identified R: 7/31/20. The repor out of room." No fu was documented. of notifying the nurs anxiety, agitation, re change in medication restlessness, and a R1's Incident Revie 8/5/20, identified R: on 8/1/20. The forr to get out of room." intervention as the 7/31/20. There was regarding this fall. R1's progress note "Resident found on out. Asked her wha going to the floor." this. R1's progress note included, "Writer no medication aide] at was on the floor." I bed. The note indic notified due to incre antianxiety medicat she hurt all over. R1's progress note included, "Aid calle | bathroom light on when the ot added to the care plan. w and Analysis report dated was found on the floor on tidentified R1 wanted to, "get urther assessment of this fall However, a new interventions be practitioner of, "frequent estlessness and request a consto decrease anxiety, egitation," was requested. w and Analysis report dated had been found on the floor midentified, "Resident wanting This listed the same 8/5/20 report for the fall on an assessment completed dated 8/6/20, included, floor by bed on knees. yelling the she was doing and she said There was no assessment of dated 8/16/20, at 3:46 p.m. of the physician was then eased anxiety and additional con was ordered. R1 indicated dated 8/16/20, at 10:28 p.m. diviter into room. Resident and writer into room. Resident and and torso was still in the | F 68 | 39 | | |

| AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER: | | ` ' | TIPLE CONSTRUCTION NG | | COMPLETED | |
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| | | 245090 | B. WING | | 09 | C 9/ 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 689 | facility." R1's progress note included, "Aid calle sitting on floor with was wanting to leave R1's progress note included, "Resident bed. Resident had slid out of her bed. leave facility and came out of here." R1's progress note "Writer observed remat next to bed this at lowest position. happened and reside of here." R1's progress note 2:15 PM writer head Writer found reside her W/C [wheel chawriter found 1" [incomposed footwear, foot pedatincontinence noted to writer what happemy head." Cool we forehead. Then footalso. R1's progress note | confused and wanted to leave dated 8/16/20, at 10:35 p.m. d nurse in to find resident arms on the bed. Resident | F 6 | 39 | | |
| | room and found res | sident on the floor next to her west position, call light within | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | | E CONSTRUCTION | COMPLETED | | |
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| | | 245090 | B. WING | | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | | s ⁻ 2 7 | TREET ADDRESS, CITY, STATE, ZIP CODE 7 BRAND AVENUE ARIBAULT, MN 55021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 689 | resident not incontine R1's progress note on right index finge. There was no incide determine when the R1's progress note physician had been index finger. R1's progress note sore right finger." R1's treatment recommonitor right index However, it did not injury. R1's progress note "Writer heard reside when writer arrived floor next to her bee up. Bed was in low place and call light Even though R1 ha there was no comp determine the reaso any pattern in time determine why the working to prevent. R1's progress note "Monitor right index bed and part of fing | dated 8/30/20, noted a bruise of and a scrape on her head. The entreport or assessment to ese injuries occurred. dated 8/31/20, included, the updated on bruise to right dated 9/2/20, included, "Ice to bright of a fall. In identified staff were to finger related to a fall. In identify which fall caused this identify which fall caused this dated 9/3/20, included, ent yelling from her room and resident was sitting on the dryelling, "Help me get back est position with fall mats in in reach." d fallen from bed 13 times, rehensive assessment to on R1 was falling from bed, of day or situation, or to current interventions were not further falls. dated 9/10/20, included, finger related to a fall." "Nail | F 6 | 889 | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING | | | COMPLETED | |
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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL 27 BRAND AVENUE FARIBAULT, MN 55021 | - | 0,20,2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 689 | "Monitor right index "Patients finger cornail bed no redness remains intact at the R1's Incident Revieg 9/15/20, identified In wheelchair on 9/15 cause of R1's fall fr The form identified emergency room for wound. R1's hospital Admist dated 9/15/20, included the formidentified emergency room for wound. R1's hospital Admist dated 9/15/20, included the formidentified emergency room for wound. R1's hospital Admist dated 9/15/20, included the formidentified emergency room for wound. R1's hospital Admist dated 9/15/20, included the formidentified emergency room for the formidentified emergency ro | a finger related to a fall." Intinues to be black around the sor warmth noted to site. Nail is time." Ew and Analysis report dated R1 had fallen from her /20. No assessment of the rom the chair was completed. R1 was sent to the for evaluation due to a head revaluation due to a head related. The finger was found on the seemed to throw hursing station. She has been reset at times. Wanting to go wilts from a CT of head noted red fracture of the left one (skull fracture). R1's summary identified R1 had skull fracture and a fracture of finger which would be splinted the nursing home. The finger age of healing, identifying it the past. The facility identified ht index finger in the the 8/30/20. However, this was physician or x-rayed until | F 6 | 89 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | | |
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| | | 245090 | B. WING _ | | | /28/2020 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | |
| F 689 | when interviewed of stated R1 had falle scream and throw I interventions she keep the low position and R1 did this she woo remembered R1 had area on her forehead but did not know with when interviewed of guardian stated the sustaining a fractur undiagnosed for soo when interviewed of licensed practical in constantly throwing threatening to throw was not enough state any assessment of determine why she was R1's behaviors assessment of R1's | up all the time, other than to one, winch was not possible required care too. on 9/24/20, at 1:31 p.m. NA-C in frequently, she would herself from bed. The only new of was to have the bed in indict mats on the floor so when aldn't be injured. NA-C and a large swollen egg sized and had broken her finger, hen this occurred. on 9/24/20, at 3:07 p.m. R1's bey were concerned about R1 red finger that went | F 68 | | | | |
| | director of nursing a good system for a are trying to improve | on 9/28/20, at 10:10 a.m. the (DON) stated they did not have when someone falls and they be this process. The nurse cident Review and Analysis | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 27 BRAND AVENUE FARIBAULT, MN 55021 | | 720,2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 689 | of these for R1's far sustained on 7/14/2 9/15/20. The DON assessment had no other falls R1 sustains and really rewhich they were unwas unable to provide termine if there what interventions anxiety/behaviors to frequently. No ass | age 21 be DON was only able to find 4 lls, which were for the falls 20, 7/31/20, 8/1/20, and did not know why this of been filled out for any of the sined. R1 had behavioral equired one on one attention, able to provided. The DON ide any assessment to was a pattern to R1's falls, and may assist R1 with her hat led to her falling so essment had been completed to determine interventions that | F 68 | 9 | | |
| | included severe co diagnosis of demer disturbance. R4 red mobility and dressin for transfer, toileting was totally inconting cares 1-3 times due R3 had 1 fall without assessment. R4's fall CAA include r/t having impaired psychotropic medic declined in both modes. | quired extensive assist for bed ng and total staff assistance g, and personal hygiene. R4 ent of bladder and rejected ring the assessment period. | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING | | | COMPLETED | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORRECTION CROSS-REFERENCE | PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPE EFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | of hypoglycemic, an narcotic, and psych incontinent of bowe recent fall from bed for safety and keep R4's care plan date related to [blank]. Slowest position. Car Follow PT and OT if function." The most "Ambulate to dining walker] support with 120 ft [feet] x1 [with was added 7/22/20 been made. R4's nursing assist: "Assist of 2 w/ [with not ambulate; fall mat was in place included, "At 7:35 plying on floor next to agitated/anxious ar stand/yell at staff. Fwhen trying to positing so resident as Ax2 [assist of 2 stafall mat was in place lowest position; roo lit." "Resident receis Seroquel [antipsychagitation/anxiety and following hour. Hos of nursing], and emnotified. Writer and about in-facility fame | ntihypertensive, diuretic, notropic medications. She is and bladder. She has had a lide Plan to continue to monitor call light within reach." Ind 6/26/20 indicated, "Fall risk Staff were directed, "Bed in light within reach; fall mat. Instruction for mobility to recent intervention, proom with FWW [front wheel in CGA [contact guard assist] in 1 staff] with FWW support". No additional updates had least Care Sheet included, hower [mechanical lift]; Does not; call light within reach." Indated 8/26/20, at 10:51 p.m. of mourse aide found resident to bed. Resident appeared and continued to try and Resident swinging arms at staff ion Hoyer [mechanical lift] sisted back up into bed with ff]. Call light was within reach; e next to bed; bed was in m was clear of clutter and well wed PRN [as needed] | | 89 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION ING | | ` ´COM | E SURVEY PLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | | SHOULD | BE | (X5) COMPLETION DATE |
| F 689 | Emergency contact visit tomorrow." When interviewed oregistered nurse (Rincident report or portall. R4's care plan R4, as she is no lor. When interviewed of family member (FM allowed to visit relaced concerned about Rinconcerned R4 have reach. LPN-D stated use the call light an intervention. When interviewed of stated, R4 was to his visits after this fall to the DON stated, the meet after each fall plan, and communice increased family visits communicated to the plan. The facility will plans. R3's admission MD | ould be worth a try; is going to try and stop for a on 9/28/20, at 10:00 a.m. N)-A stated there was no ost fall follow-up report on R4's was incorrect about walking ager able to ambulate. on 9/28/20, at 11:35 a.m. a)-B stated they had not been ted to COVID and was 4's falls. FM-B stated R4 osee them out her window for spoken to them about decrease anxiety. on 9/28/20, at 12:35 p.m. and fallen a couple times, hey put a mat on the floor next e sure R4 has her call light in ed R4 would not know how to d was unsure why that was an on 9/28/20, at 3:05 p.m. RN-A ave increased family window on aide in preventing more falls. The interdisciplinary team should, update care sheets and care cate the change, but the | | 889 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | | TE SURVEY MPLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | including a stroke a extensive staff assi daily living (ADL's), of falls prior to adm admission with no idelusions or hallucing R3's falls CAA date triggers for falls r/t history of falls, and Resident has had a following hospitalizate weakness. He had increased right side OT at this time with community. Resider the daily antihyperter and hypoglycemic rof bowel and bladder vision, and hearing of falls prior to admission which something on the fluoritor for safety, follow therapy reconvould be completed R3's Fall Review Exincluded a checklistic before admission, fuse that can increase deficits, incontinent concerns with balar findings or indication factors would be added to lack of safety. R3's care plan date related to lack of safety. | and dementia. R3 required stance with most activities of was unsteady, had a history ission and had fallen since njury. R3 did not have nations. d 8/19/20, included, "Resident naving impaired balance, daily antidepressant use. recent decline in mobility ation for increased overall a CVA [stroke] and has weakness. He is in PT and the goal of returning to the ent is at increased risk of falls nsive, psychotropic, diuretic, medications. He is incontinent er. He has impaired cognitive, Resident does have a history ission and has had one fall here he was reaching for oor. Plan to continue to keep call light in reach, and mmendations. Care planning d. valuation dated 8/15/20, at of risk factors including fall all after admission, medication se falls, cognition and sensory se, confined to chair, and ince. There was no analysis of non how any of these risk | | 589 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | TIPLE CONSTRUCTION NG | | COM | E SURVEY IPLETED |
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| F 689 | and free from falls. Answer call light pr for transfers, follow in reach, proper for items were in reach R3's progress note included, "Writer walked in and saw floor. Resident was eating supper. Aid resident up using h Resident states that dropped and he we his wheelchair. Re on the chair that was at the medicine "Pt [patient] was att RN heard some so his wheel chair and saw the resident was at the medicine "Writer was called floor. Resident was and had his hands Resident was sitting up. Resident his wheel chair to g slipped off the bed bed. Resident's vit | "Staff were directed to, omptly, use a mechanical lift therapy instructions, call light of the state of the s | F 6 | 89 | | | |
| | | dated 9/4/20, 10:32 p.m. ansferred and was found | | | | | |

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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 689 | "Resident was layir Resident was holdi waiving it in the air. right next to him wi Resident states he his room and using out of his way. Resident while do there were no cats assessment of R3's room, even though or delusions at the assessment. When interviewed of LPN-C stated other care plan, no new i any of these falls, any post fall assess The facility had not determine root cau prevent the falls from increased confusion not assessed other which the family definiterdisciplinary teamext day and place that assessment, brown and RN-A states. | dated 9/11/20, included, ag on back on the ground. In handle gripper in hand and Residents wheelchair was the the breaks unlocked. It was chasing the cats out of the handle gripper to get them sident then fell out of bing this." "Resident was told in this facility." There was no as belief there were cats in his R3 had not had hallucinations time of the comprehensive on 9/28/20, at 10:31 a.m. In than what was already in the interventions were added after LPN-C was unable to provide sment for any of these falls. It assessed each fall to see, nor place interventions to see, nor place interventions to see, nor place interventions to see than to offer psych services, actined. Normally, the services would assess each fall the new interventions based upon ut this had not been done for the on 9/28/20, at 11:44 a.m. the ted the facility was not willing | F 68 | 9 | | |
| | resident's who had facilities, "Risk mar | mentation related to any of the fallen as it is part of the nagement." They were unable umentation that R1, R4, or | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION ING | | TE SURVEY MPLETED |
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| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z 27 BRAND AVENUE FARIBAULT, MN 55021 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | R3's falls had ever assessed to determ prevent further falls A facility policy titled Management, revis procedure for staff a fall, "staff will mor resident's response intervention put in p72 hours post fall. 2 staff will re-evaluate appropriate to contiinterventions. As ne provider will assist not previously ident documented that fa will implement appr prevent serious injube updated to reflect R10's quarterly MD cognitively intact willing disease. R10 up assistance with R10's Speech Ther included a diagnosi dysphagia (difficulty throat) and oral phasin the mouth). The risk for aspiration of Recommendations consistency, small (chewing), swallow bite/sip, slow pacing between liquids/soli | been comprehensively nine interventions that may from occurring. d, Fall Prevention and ed 2/2020, indicated follow-up after a resident had sustained nitor and document the eto and the effectiveness of place to prevent further falls for 2. If resident continues to fall, ethe situation and whether it's nue or change the current reded, the resident's medical reconsider possible causes ified. 5. If it is determined and lls may be unavoidable, staff opriate interventions to any from falls. 6. Care plans will be trained to the diagnoses of diabetes and required supervision and set reating. S dated 7/14/20, included the diagnoses of diabetes and required supervision and set reating. apy evaluation dated 3/26/20, so of pharyngeal phase of swallowing for issues in the ase dysphagia (due to issues evaluation noted R10 was at | F 6 | 689 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED C | |
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| | | 245090 | B. WING | | 09 | /28/2020 | |
| | PLEASANT MANOR LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 28 R10 would be appropriate for diet upgrade. | | | STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021 | | , | |
| PRÉFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 689 | R10's nutritional stridentified a risk factidet. No analysis of completed. R10's care plan danutritional alteration meals; had diet resultational Dysphaging ground or are minor pieces, they are meand could have reduirected to monitor physician as needes swallowing problem. R10's undated nursincluded mechanical R10's Nutrition Evaluated a mechanical meat. Speech their all meats ground, using the staff had grief of the staff had grief as the staff had grief and the staff had grief | atus CAA dated 4/10/20, stor of a mechanically altered of this risk factor was ted 4/1/20, included, risk for a related to coughing during strictions which included NDD2 is Diet, level 2- meats are to be seed no larger than 1/4 inchoist, with some cohesion] diet quested puree. Staff were and for signs and symptoms of ans. sing assistant Care Guide all soft diet with pureed meat. Aluation dated 4/16/20, anical soft diet with pureed meat. Aluation dated 4/16/20, anical soft diet with pureed meat. Evaluation dated 7/14/20, full upper and lower dentures. I on 9/25/20, at 12:42 p.m. R10 are coughing while eating. At noted R10 was eating a regular in a bun. R10 stated it was | | 39 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | IPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245090 | B. WING | · · · · · · · · · · · · · · · · · · · | 09 | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
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| F 689 | texture and to prove potato salad, no rate lettuce." When interviewed aide (DA)-A stated mechanical soft die with ground meat, she normally does When interviewed (CK)-A stated, a meground meat, no be cook is the person correct diet is served. When interviewed stated R10 does con unaware R10 did neather should go get a nutrin the dining room. When interviewed stated she normally today got a regular grilling them. R10 dentures, but forgo have to remind her them. At 1:39 p.m. asked her if she was with the salad she interviewed to the salad she was with the salad she interviewed to the salad she was with the salad she interviewed to the salad she was with the salad she interviewed to the salad she inter | ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating. on 9/25/20, at 1:12 p.m. cook echanical soft diet should have read or hard vegetables. The responsible to ensure the ed. on 9/25/20, at 1:21 p.m. NA-Fough at meals, she was ot have dentures in. NA-Fis coughing like that, they rise to assess if no nurse was on 9/25/20, at 1:34 p.m. R10 y gets a ground burger, but whole burger as they were stated she normally wore her to put them in or help her with R10 was coughing and NA-H | | 39 | | |
| | wished for an upgra | ade, but would have to sign a statement. R10 did not have | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION ING | | ATE SURVEY OMPLETED |
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| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI 27 BRAND AVENUE FARIBAULT, MN 55021 | | 0/20/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | HOULD BE | (X5) COMPLETION DATE |
| F 689 | a risk versus benef she given the risks a regular hamburge. When interviewed of Cook-A stated they who had signed a risk for a diet upgrade, they can provide it. these. R10 should ground meat diet a hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Groonsistency and papureed food if desire. When interviewed or registered dietician coughing during a risk beginning to the DON, food servitherapy. This had if facility should not provided without risks begand a form signed. When interviewed of DON and RN-A state the correct diet texts. | its statement signed nor was of choking when provided with er today. on 9/25/20, at 3:08 p.m. have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the sordered and not a regular cion Form provided by Cook-A had been completed by dindicated R10 was to have a round Meat NDD2 diet attent could downgrade to red. on 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to rice director and speech not been done for R10. The provide an upgraded texture eing explained to the resident on 9/28/20, at 2:37 p.m. the ted it is important to provide ture for residents with its. A nurse should be notified | F6 | 689 | | |
| | cognitive impairme | dated 9/4/20, indicated no nt with diagnoses including, he MDS noted R5 had | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | FIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245090 | B. WING | ····· | 09 | C / 28/2020 |
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| F 689 | swallowing medica period. The MDS for oversite, set up whaltered textures. R5's Speech Thera indicated diagnose and oral phase dysindicated R5 had mathematicated the evaluation had dentures that did nowithout dentures, For consistency solids. Advanced. R5 was of materials into the penetration (passa and/or asphyxiation. R5's Care Assessing dated 1/20/20, indimechanically altered completed, but was planning. R5's care plan date risk for nutritional apain front thorax and diet. Staff were direct and report to physical dysphagia when early solved the staff was changed to R5's Progress noted diet was changed to R5's Nutritional Evaluation. | cing during meals or when tions during the assessment curther indicated supervision, en eating and mechanically apy Evaluation dated 1/25/19, so for cerebral infarction (stroke) sphagia. The evaluation further hissing teeth, and at the time of full upper and partial lower of fit. The evaluation indicated as could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx,) in. Then the evaluation analysis is noted to proceed to care and 3/20/20, indicated R5 was at alteration related to chronic and diet restriction for NDD3 ected to monitor, document cian for signs or symptoms of | F 6 | 89 | | |

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| F 689 | R5's Care guide for and independent in from MDS 9/4/20, C physician order and R5's lunch tray ticked Dysphagia Advance further directed to phamburger on bun, vegetables, backed lettuce, soft ice created buring an observating sat alone at a tawhile she atte her mind whole hamburger with covered the burger. There were various area including nursistopped to see why p.m. R5 was observed to see why p.m. R5 was observed the dining room. When interviewed of stated R5 should have been ground a potato chips or who when interviewed of stated she has occasing light manner. When interviewed of stated she has occasing light manner. | estaff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, I care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw I beans, no bacon, shredded am and milk. sion on 9/25/20, at 12:50 p.m. able and was noted to cough leal. R5's plate contained a with a wedge of lettuce that on a bun and potato chips. I staff throughout the dining ling and dietary, but no one of R5 was coughing. At 12:52 wed to be shaking and asked hurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A lave received ground meat, I, soft cooked vegetables. R5 die a bun, the burger should and should not have received on 9/25/20, at 1:10 p.m. R5 desional seizure that are like, | F 6 | 689 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

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| F 689 | For the noon meal mechanical texture ground hamburger, was the cook's respresident is getting to the cook's respresident is getting to the cook stated staff should coughing and should have received the cook who gave her the worder of the cook is resident is upgraded texture if been signed. The morder from the physicand benefit form. Roon 9/25/20 at 3:08 should have receiven not, the Cook is rescorrect diet. The facility Refusal and Benefits policy resident would be in benefits of necessary opportunity regarding care. The resident times and if resider documentation should have received the cook is rescorrect diet. | no bread or hard vegetables. provided on 9/25/20, a should have included, no bun, potato salad and beans. It consibility to make sure a he appropriate texture. on 9/25/20, at 1:21 p.m. NA-F check on residents who are ld get a nurse. R5 should correct diet and did not know wrong diet. on 9/25/20, at 1:40 p.m. orted both dietary and nursing | F 6 | 89 | | |

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| F 689 | Continued From pa | ge 34 | F 68 | 9 | | |
| F 725 SS=F | Dysphagia Mechan Level 1 are allowed foods may be groun no larger than one is should be easy to do Moistened ground of fish. Moist ground with gravy or sauce pureed bread mixes and slurred breads thickness of product products. Vegetable vegetables. Vegeta | | F 72 | 5 | | |
| | the appropriate conprovide nursing and resident safety and practicable physical well-being of each president assessment and considering the diagnoses of the factordance with the at §483.70(e). §483.35(a)(1) The factor of personnel pursing care to all resident care plans | ave sufficient nursing staff with inpetencies and skills sets to direlated services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care in number, acuity and cility's resident population in a facility assessment required facility must provide services are of each of the following on a 24-hour basis to provide esidents in accordance with | | | | |

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| F 725 | this section, license (ii) Other nursing polimited to nurse aid §483.35(a)(2) Exceparagraph (e) of this designate a license nurse on each tour This REQUIREMENT by: Based on observative review, the facility of staffing to provide of planned needs for R1, R3, R8, R13 ard LPN-A, LPN-D, NANA-A, RN-A, HSK-members (FM)-A, This had the potent residents. Findings include: R5's quarterly Minimically for the body and a seize physical assistance bathing. R5 Care Assessment 1/20/20, included, activities of daily live and toileting. R5's care plan updaneeded assistance shower/bath with or | ed nurses; and ersonnel, including but not es. Ept when waived under section, the facility must ad nurse to serve as a charge of duty. NT is not met as evidenced tion, interview and document ailed to ensure sufficient or the individualized care 8 of 8 residents (R5, R7, R4, and R12), 12 of 15 staff (LPN-B, -D, NA-C, NA-J, NA-B, NA-F, A and NA-C) and 1 of 3 family reviewed for sufficient staffing. The tidal to affect all 42 current from staff for toileting and ent Worksheet (CAA) dated R5 extensive assistance with ing (ADL) including bathing ated 8/12/20, included, R5 | F 7 | 25 | | | |

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| F 725 | licensed practical ranot getting the time toileting, bathing and enough staff. R5 of the word of the w | on 9/24/20, at 12:23 p.m. nurse (LPN)-A stated, R5 was ely care she needed with and hygiene as there was not lid complain about this. on 9/24/20, at 2: 20 p.m. R5 y is very short staffed. I wait an answer to my call light." a long time to get help to go to "I should have a bath every wer every Wednesday. The aid take a shower because it takes t. Sometime, I get neither here are not enough aids on." to R5. on 9/24/20, at 3:22 p.m. a NA)-D stated R5 required thing and toileting, but often assistance as they do not to get to everyone timely. ave to skip R5's bath as they h time. on 9/24/20, at 3:45 p.m. a nurse (LPN)-B stated, R5 getting her shower on a regular psetting to her, but they were | F 72 | 5 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
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| F 725 | had a lot to do and time to get in the ba another shower that that we never got do Shower/bath record 2020: R5 received again until 8/17/20, 8/24//20. R5 received again until 9/21/20. Review of R5's cal p.m.) to 9/29/20 (2: the call light 166 time wait time was over 41.5% of the time. R7's admission MD moderate cognitive of a stroke. R7 was required assistance transfer on and off R7's ADL (activities Rehab Care Assest dated 9/25/20, included in mobility, of bowel and bladd toileting upon requer R7's care plan date required assistance dependent assist, opersonal hygiene s occasionally incont with toilet use." | or until 6 p.m. After 6 we still ended up not having enough ath R5 wanted. There was also it was supposed to get done one." It dis dated July to September a shower on 7/19 but not and then not again until ed a bath on 9/13/20, but not I light log from 9/1/20 (6:53 24 p.m.), indicated, R5 used nes. Of the 166 instances, the 20 minutes on 69 occasions or as dated 7/28/20, included impairment with a diagnosis occasionally incontinent and a by one staff person to of the toilet. In of daily living)/Functional sment Area Worksheet (CAA) uded, R7 has had a recent was occasionally incontinent er, and needed assistance for | F 72 | | | |

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| (EACH DEFICIENCY | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SH | OULD BE | (X5) COMPLETION DATE |
| nursing assistant (Neek she found R7 when she started he was not enough started hygiene needs in a when Interviewed was lying in bed. R facility is very bad. There seems to be facility. Call lights chour. I push the call bathroom and no owet myself. I feel he chair and embarrast cleaned up and chabrow was furled an R7 stated this happ. When interviewed on ursing assistant (New wait for assistance her incontinent. This Most residents wait time to receive an a has assisted R7 aff secondary to waiting time for the call light that there have been beginning of the she soiled and need as night shift is custom one licensed practionurse (RN) for the facility. | NA)-C reported the previous of soiled halfway up her back er shift. NA-C reported there aff to meet R7's toileting and timely manner. On 9/25/20, at 2:00 p.m. R7 of stated, "Staffing for the liblame the State because no staffing guidelines for this an go unanswered for over an illight when I need to go to the ne comes until it is too late. I numiliated about wetting in the seed about needing to be anged." R7 looked angry, her did her face became slightly red. Dens at least once a week. On 9/25/20, at 2:35 p.m. NA)-D stated R7's often has to to the bathroom which makes is was always upsetting to R7. It for an extended period of answer to their call light. NA-D ter R7 was incontinenting for a prolonged period of ant to be answered. NA-D stated en, "Too many times," at the ift when several residents are sistance. NA-D stated the narily staffed with two NA's and cal nurse (LPN) or registered 42 current residents in the | F 7 | 25 | | |
| | | | | | |
| | Continued From participation of the shape of the call light that there have beginning of the shapility. When interviewed an assisted R7 affiscional secondary to waiting time for the call light that there have beginning of the shapility. When interviewed an interviewed an assisted R7 affiscional secondary to waiting time for the call light that there have beginning of the shapility. When interviewed an interviewed an interviewed and as assisted R7 affiscional secondary to waiting time for the call light that there have beginning of the shapility. When interviewed an inject and need as night shift is custom one licensed practicularse (RN) for the facility. | PROVIDER OR SUPPLIER NT MANOR LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 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 | PROVIDER OR SUPPLIER NT MANOR LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 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. 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| F 725 | morale among staff of this. R7's call light response 9/22/20, at 3:51 a.m. showed the call light the seven day periorinitiated, 11 (or 21.515 minutes to receive 14%) of these alert to receive a response R4's admission Min 6/29/20, included, rwith diagnoses incluarthritis. R4 require toileting and limited hygiene. R4 was nwas occasionally in times during the as R4's incontinence of dated 7/1/20 indicatorinary incontinence assistance with toile incontinence." "She and OT [occupation the goal of returning uses incontinence play. Plan to continuand complete perior HS [night], and with R4's significant chaincluded severe condependent upon stafty incontinence and was all significant | f and residents is low because onse time logs dated from n. to 9/28/20, 9:25 a.m. It was engaged 51 times over od. Of the 51 call light alerts (5%) of these alerts took over ve a response. Seven (or se took longer than 20 minutes se. Inimum Data Set (MDS) dated moderate cognitive impairment uding diabetes, dementia and ed extensive assistance with assistance with personal of on a toileting program and continent of urine (less than 7 sessment period). Care Area Assessment (CAA) ted, "Resident triggers for er/t [related to] need for | F 72 | 25 | | | |

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| F 725 | "Resident triggers f toilet use and bladd declined in both mo She has recently er life cares. Resident aid in keeping skin current toileting plar [every] AM [morning incontinent episode R4's only Bowel and medical record was R4 was continent on R4's care plan date "Alteration with elim to, "Assist of 1 with not been updated s 8/27/20, MDS noted incontinence to total in assistance needs hygiene. R4's nursing assistance needs hygiene. R4's nursing assistants of toileting needs. During continuous of starting at 10:34 a.r. if she would like to declined. No encouprovided. No addition incontinence cares licensed practical needs and starting at 10:34 a.r. if she would like to declined. No encouprovided. No addition incontinence cares licensed practical needs and starting at 10:34 a.r. if she would like to declined. No encouprovided. No addition incontinence cares licensed practical needs and starting at 10:34 a.r. if she would like to declined. No addition incontinence cares licensed practical needs and starting at 10:34 a.r. if she would like to declined. No addition incontinence cares licensed practical needs and starting at 10:34 a.r. if she would like to declined. No addition incontinence cares licensed practical needs and starting at 10:34 a.r. if she would like to declined. No encouprovided. No addition incontinence cares licensed practical needs and starting at 10:34 a.r. if she would like to declined. | or urinary incontinence r/t ler incontinence. Resident has ability and cognitive function. Incolled in hospice for end of I uses incontinence products to dry. Plan to continue to with In and complete peri cares q g], HS [night], and with each | F 7 | 25 | | |

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| | | 245090 | B. WING | | 09 | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZII 27 BRAND AVENUE FARIBAULT, MN 55021 | | 720/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 725 | 1:58 p.m. NA-F and and changed R4's without being assisted hours. The DON stoneds very well. Rowas present review and Bladder assess 6/24/20, noting it in bladder. RN-A reviidentified R4 had not Bladder assessmer significant decline in June of 2020. RN-an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least every well. In the property was present review and Bladder assessmer significant decline in June of 2020. RN-an updated assess change MDS comp explained they were R4 was on their wo should have been of changed at least every was the wait to should have should have been of changed at least every was the wait to should have wait to should have been of the property of the | In NA-B assisted R4 into bed visibly wet brief. In 9/25/20, at 2:05 p.m. NA-F ey had assisted R4 with 30 a.m. NA-F stated they had ist R4 to lie down or toilet of at 7:30 a.m. NA-F stated, of us on the floor, we try our NA-B stated, "It's really terrible we should be." NA-F and d R4 had gone 6.5 hours ted with incontinence cares. In 9/28/20, at 3:05 p.m. the (DON) stated, she thought R4 with incontinent cares every 2 tated she did not know R4's egistered nurse (RN)-A who wed R4's most recent Bowel sment, which was dated dicated R4 was continent of ewed R4's medical record and of the had an updated Bowel and int, even though she had an condition since admission in A stated R4 should have had ment with the significant leted in August 2020. RN-A e behind on assessments and rk list, "to be caught up." R4 shecked for incontinence and very 2 hours. In 9/1/20 - 9/29/20 revealed th 20 times. Of the 20 time was over 10 minutes on a 40 minutes on one occasion, | | 725 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | COM | E SURVEY PLETED |
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| | | 245090 | B. WING | | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | | 27 B | EET ADDRESS, CITY, STATE, ZIP CODE BRAND AVENUE RIBAULT, MN 55021 | 1 03/ | 20/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 725 | 8/20/20, included, s with diagnoses incluinjury) and dementiassistance with most (ADL's) and did not falls with injury sinchad a discharge MER1's care plan date AEB [as evidenced admission related to secondary to TBI and disturbances." The "Resident will be sashould incident occ "Provide one on one and wheeling her defrom 7/21/20 thorough the facility provided from 7/21/20 thorough the facility provided from 7/21/20, 8/16/20, 8/12/20, 8/16/20, 8/19/20, 8/16/20, 8/19/20, 8/16/20, 8/19/20, 8/16/20, 8/19/20, 8/16/20, 8/19/20, 8/15/20 after sustain agitation. Summary fractured skull and revealed: | num Data Set (MDS) dated evere cognitive impairment uding TBI (traumatic brain a. R1 required extensive st activities of daily living ambulate. R1 had 2 or more e the prior assessment. R1 DS dated 9/16/20. d 9/2/20, included, "Fall risk by] multiple falls since or lack of safety awareness and Dementia with behavioral goal for R1 was listed as, afe and free from serious injury ur." Staff were directed to, e care, such as taking outside bown the hall." d a running list of R1's falls and 1/20, 8/1/20, 8/5/20, 8/6/20, 12/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 8/16/20, 9/3/20, 0). summary dated 9/16/20, ansferred to the hospital on ning a fall related to increased details R1 incurred a | F 7 | 725 | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ONSTRUCTION | COM | E SURVEY IPLETED |
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| F 725 | R1's progress note included R1 had att several times after Facility transferred started to yell out a and back. R1 reporneck and back. R1 wheelchair. Facility ratio as the facility of R1's physician was confirmed for the Rhospital. R1's guard transfer situation. R1's progress note included, R1 was transfer situation. R1's progress note included, R1 was transfer was giventeams. The floor nuinform that R1 was safety concerns. R1's progress note included, R1 was narked behaviors: put herself onto the louder than her usuand 1:1, 2:2, 3:3 weremained aggressing 911 to send R1 to be for further evaluation. When interviewed of stated there were to one attention, but the cover a unit of 30 repossible. | dated 9/16/20, at 5:35 p.m. tempted to crawl out of bed returning from the hospital. R1 to her wheelchair, R1 then and reported of pain in neck ted to facility of pain in her started to stand up from her initiated a 2 to 1 staff to R1 determined R1 was not safe. contacted and consulted and to be sent back to the dian was informed of the dated, 9/16/20, at 6:24 p.m. ransferred back the hospital. And to the police and transport arse called the hospital to returning to them due to dian dated 9/16/20, at 6:28 p.m. oted to have continued swore at staff, attempted to a floor, yelling and hollering telling, R1 was extremely agitated are attempted and R1 we towards staff. Facility called the emergency department (ED) on per physician's orders. Son 9/24/20, at 1:00 p.m. NA-B times when R1 required one on the energy only had one or two staff to desidents, so this was not the energy of the energ | F7 | 25 | | | |

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| F 725 | emergency room s would not take R1 they did not have e enough. When interviewed stated R1 required time to prevent her not have the time to NA-D stated she w when arriving for howet," in her incontinuted with the was not attention. When interviewed stated there was not R1 and keep her sa attention. When interviewed DON stated due to could not be met at | e fell a lot. on 9/24/20, at 2:56 p.m. the ocial worker stated the facility back to the facility because nough help to watch her well on 9/24/20, at 3:22 p.m. NA-D a significant amount of staff from falling and they just did o stay with her all the time. orked the day shift and often er shift would find R1, "sopping | | 25 | | |
| | 8/15/20, revealed Fimpairment. R3 red staff physical assis diagnosis included swallowing concern mouth when eating mouth/cheeks or red | nimum data set (MDS), dated R3 had moderate cognitive quired supervision and one tance for eating. R1's a stroke. R3 had the following as: loss of liquids/solids from or drinking, holding food in esidual food in mouth after ang during meals or when | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION IG | COM | TE SURVEY MPLETED C |
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| F 725 | staff, "The resident with adequate eatinall meals in the din supervision-not to is provided." When interviewed stated she worked "understaffed." Note that the provided morning especially if they reassistance with me required individual not eat too quickly get enough fluid. Nover 40 minutes to in the dining room. When interviewed stated, R3 required make sure he ate that staff were available around the room, when interviewed stated, there were assistance in the did to figure out how to entire time due to or required assistance. During observation wheeled self into the wheel chair back as the staff was sure he ate to the staff was available around the room, wheeled self into the did to figure out how to entire time due to or required assistance. | tions. It updated 9/24/20, directed to needs a calm, quiet meal timeing time. The resident requires ing room r/t [related to] close receive meals until supervision on 9/24/20, at 12:56 p.m. NA-A day shift and considered it, A-A reported residents waited to a gcares prior to breakfast, equired two staff and echanical lift. NA-A stated, R3 assistance for cueing him to or take too big of a bite and to IA-A noted R3 often had to wait eat until they had enough staff | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
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| | | 245090 | B. WING | | 05 | C 0/ 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUTH ACTION SHOUTH CORRECTIVE ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH ACTIO | OULD BE | (X5) COMPLETION DATE |
| F 725 | stated there is never room to feed every | ge 46 on 9/25/20, at 1:21 p.m. NA-Fer enough staff in the dining one. "On a good day, we are es to assist all the residents." | F 7: | 25 | | |
| | was cognitively inta Parkinson's disease assistance of 2 state and one person phy R8's care plan, last staff, "Alteration in | PS, dated 8/10/20, included, R8 ct with a diagnosis of e. R8 required physical if for transfers and supervision ysical assistance for toileting. revised 8/24/20, directed elimination r/t [related to] Assist of 1 with toileting as ." | | | | |
| | LPN-A stated R8 w the morning and ne afternoon. LPN-A n her call light on but | on 9/24/20, at 12:23 p.m. as independent with cares in seded more assistance in the oted R8 might not even turn holler out for staff. | | | | |
| | stated, "We barely more independent a residents who requive when interviewed a stated there was nowhen she needed it with stiffness and don her own when h | touch base," with R8 as she is and staff need to help with ired more assistance. on 9/28/20, at 10:37 a.m. R8 of enough staff to help her t. R8 stated she has problems ecreased ability to do things er Parkinson's medication was ff tell her they have a half hour | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | E CONSTRUCTION | COM | E SURVEY IPLETED | | |
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| | | 245090 | B. WING | | | | C 28/2020 | | |
| | ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | | | | | |
| PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE | | |
| F 725 | on each side of the but it is often over to they do not have er time. R8 stated shift the bathroom, she minutes to get on other back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and unable to care for her back to hurt and dated August 2020. Carbidopa-Levodop Parkinson's disease stiffness, tremors, secontrol) five times of 4:00 p.m., 7:30 p.m. noted as being admeach opportunity, be not noted. When interviewed of LPN-D stated getting her medicated R8's call light log, discluded, R13 active two incidents, the reand 40 minutes. Or time was between a incident, the responsibility of the responsibility | time her medication is due, hat. R8 stated staff tell her hough staff to get it to her on a does not get enough help to often has to wait 20-40 or off the toilet. This causes dishe gets even more still and derself even more. ministration record (MAR), included an order for oa (a medication for treating a symptoms such as muscle spasms, and poor muscle laily; 5:55 a.m., 10:00 a.m., and 11:30 p.m. R8 was hinistered the medications at but the time administered was an 9/28/20, at 10:58 a.m. anted her medications on the R8 reported concerns with ions on time in the evening. ated 9/8/20 through 9/25/20, ated her call light 12 times. On two incidents the response to and 50 minutes. On one are time was over 100. S dated 9/18/20, included the a diagnosis of multiple uired two staff for toileting and | | 725 | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | TIPLE CONSTRUCTION NG | COM | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, 2 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 720/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 725 | risk for skin breakd assistance. The car call light in reach are When interviewed a stated R13 was total cares. Sometimes I breakfast as they do her up before breakfast as they do her up stated when coming they would find R13 often the only staff competent to use the get R13 up, and duin bed at supper time they just didn't have her up. When interviewed a stated she is inconting medical condition, speriods of time to be addition, she often because there is not this was upsetting. R13's call light logs reviewed. R13's call light logs reviewed. R13's call of and 20 minutes and 30 minutes and 40 minutes between 40 and 50 between 50 and 60 betwee | own and required staff are plan indicated to keep the and answer promptly. on 9/24/20, at 1:31 p.m. NA-C ally dependent on staff for R13 had to stay in bed for idn't have enough staff to get afast. R13 would prefer to get a when they need her to be. The saturated by the time they to her after breakfast. on 9/24/20, at 3:22 p.m. NA-D gon for the afternoon shift a soaked in urine. NA-D was on afternoons who was the mechanical lift needed to be to this, often R13 had to stay the enough help to always get a sine of urine due to her she often has to wait extended to get out of bed out enough staff to help her up. | F 7 | 25 | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | C C C C C C C C C C C C C C C C C C C | | | | |
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| | | 245090 | B. WING _ | | | 28/2020 |
| | NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 725 Continued From page 49 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 arter disease, asthma/chronic obstructive pulmona disease or chronic lung disease and respirato failure. R12's medication and treatment administratio report (MAR/TAR), dated August 2020, directe 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 a 9/17/20. The MAR/TAR directed "Ensure resic has bipap on every overnight, every night shift cpap placement. Please ensure Cpap is in pla every hour overnight." This was not marked a 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 a 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 family had concerns about staffing. LPN-B R1 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 nigh and oxygen nasal cannula during the day to | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | • | |
| PRÉFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 725 | R12's quarterly MER12 had moderate was on hospice se care. R12's diagnod disease, asthma/cl disease or chronic failure. R12's medication a report (MAR/TAR), staff, "Connect 02 bedtime." and "Oxycannula while at remarked as comple 9/17/20. The MAR/has bipap on everycpap placement. Pevery hour overnig completed on 9/4/2 "Bipap-Nurse must sleeping and at nigcompleted the night on 9/24/20, at 3:48 family had concern was, "slower," and residents. On 9/25/20 at 10:3 R12, (FM)-A stated through video. R12 and oxygen nasal cassist with respirat would notice times not applied, or not amounts of time, n 3:20 a.m. to 3:50 a | OS dated 8/14/20, included, cognitive impairment. R12 rvices and required oxygen ses included coronary artery pronic obstructive pulmonary lung disease and respiratory and treatment administration dated August 2020, directed 1.5 L [liters]/min [minute] at ygen at 1.5L/min per nasal st and at night. This was not ted on the night of 9/4/20 and TAR directed "Ensure resident yovernight, every night shift for lease ensure Cpap is in place ht." This was not marked as 20 and 9/17/20. and a put on use daily when ht." This was not marked as at of 9/4/20 and 9/17/20. 5 p.m. LPN-B stated, R12's and as about staffing. LPN-B R12 "needier," than other | | 5 | | |

| | OF DEFICIENCIES DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | TIPLE CONSTRUCTION ING | - (X | (3) DATE SURVEY COMPLETED |
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| | | 245090 | B. WING | | _ | C 09/28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA 27 BRAND AVENUE FARIBAULT, MN 55021 | ATE, ZIP CODE | 0012012020 |
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| F 725 | reported, during the the facility to alert set the interview, R12 when she was not eneeded, like she was R12 was deteriorated physically and was the oxygen. FM-As she noted no came movement detected 11:34 p.m. and 4:00 required frequent in was on properly. FI she felt like a burde had informed the disconcerns and there improvement. R12's call light log, included, R12 active Eleven of those we minutes. Six were a minutes. | ese instances, she would call staff, without response. During noted she did not feel well getting the oxygen she as in a "daze". FM-A reported ing both cognitively and more confused when not on stated, on 9/18/20 to 9/19/20 era activity, indicating no d, in R12's room between 9 p.m. FM-A noted R12 nonitoring to ensure her bipap M-A reported R12 had told her en to staff. FM-A reported she irector of nursing of her e was no resolution or dated 9/1/20 to 9/29/20, ated the call light 66 times. The answered in 10 to 20 answered between 30 to 40 answered between 30 to 40 answered between 40 and 50 answered in over 60 minutes on 9/24/20, at 12:23 p.m. If were not enough staff to care a eaide on west side of the care were not getting the timely care mely toileting, bathing and oad was stressful and if burnout and turnover. LPN-A cussed concerns with DON and there had been no eported she helped the with cares when she was able completing treatments and | | 725 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | |
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| | | 245090 | B. WING | | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 7 BRAND AVENUE ARIBAULT, MN 55021 | <u> 0911</u> | 20/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 725 | medication pass for there was an overa getting the timely as hygiene. When interviewed or reported she was proported to happointments and was proposed to happointments and was proposed to happointments. | ge 51 r residents. LPN-A reported ll concern with resident not essistance with bathing and on 9/24/20, at 1:31 p.m. NA-C ulled away from her nursing nelp with electronic medical wound rounds. There was not eaff to provide oral care and | F 7 | 25 | | | |
| | peri-cares for reside busy with their own time baths and shor residents were not a evening cares when chart a resident refundant not been offere bathed, when they | ents. The nurses were too duties to assist. Most of the wers were missed and assisted with morning and in they preferred. Staff would used a bath, when the resident ed, or chart a resident was were not bathed. This had oth the DON and administrator | | | | | |
| | stated she worked times when she wo building. Resident extended periods o hour. They just coumeal times resident "Short staffing is a been reported to the | on 9/24/20, at 3:22 p.m. NA-D the night shift and there were uld be the only nurse aid in the call lights were on for f time- sometimes over an uld not get to them timely. At the complain of cold food. daily occurrence." This had e administrator but was told they could do about it. | | | | | |
| | stated there was or residents. Nurses of personal cares for addition to their reg were not able to ma | on 9/24/20, at 3:45 p.m. LPN-B ne or two aides for 30 were expected to provide 5 residents each shift in ular duties. Sometimes, they ake sure resident treatments when staff come from a | | | | | |

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| | | 245090 | B. WING | | 05 | C 0/28/2020 |
| | 245090 AME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | • | 720,2020 |
| PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESPONDED TO THE APPOPER DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 725 | staffing agency, the they do not have en their work. LPN-B management and with the work. LPN-B management and with the staff out," becan time to meet reside when interviewed administrator, assist RN-A were intervie facility assessment staffing needs to maneds. Typically, the staff have manoticed "a lot of staff administrator noted dynamics and cultus staffing concerns. was committed to it and chipping in with she felt there was a but felt the communication many staff and reported there was too many staff and reported there was consus was down. The facility staffing staff, "Our facility p staff with the skills provide care ad sea accordance with resident was consus was down. | by are reluctant to return as hough time to complete all of had reported this concern to was told they had enough staff. on 9/25/20, at 11:12 p.m. ing assistance seem to be, use they do not have enough ent needs. on 9/28/20, at 3:36 p.m. the stant administrator, DON and wed together. There was no to determine the specific seet resident care planned here should be 1 nursing sidents. DON stated there to complained about call light arly at night time. RN-A stated, de it seem so drastic" but anding around." The dishe was working on team are change in response to The administrator reported she incation was poor. DON a situation where there was less work got done. RN-A | F 7: | 25 | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 245090 | B. WING _ | | | C / 28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 27 BRAND AVENUE FARIBAULT, MN 55021 | | 20/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 725 | requirements of dire | ect care staff are determined residents based on each | F 72 | 5 | | |
| | Food in Form to Me CFR(s): 483.60(d)(3 | eet Individual Needs | F 80 | 5 | | |
| | §483.60(d) Food ar Each resident recei | nd drink ves and the facility provides- | | | | |
| | to meet individual n This REQUIREMEN by: Based on observat review, the facility for accordance with res | NT is not met as evidenced ion, interview, and document ailed to prepare food in sidents needs for 2 of 3 R10) reviewed who required | | | | |
| | Findings include: | | | | | |
| | cognitively intact wi | S dated 7/14/20, included th diagnoses of diabetes and required supervision and set eating. | | | | |
| | included a diagnosi dysphagia (difficulty throat) and oral pha in the mouth). The risk for aspiration or Recommendations consistency, small I (chewing), swallow bite/sip, slow pacing between liquids/soli | apy evaluation dated 3/26/20, s of pharyngeal phase a swallowing for issues in the ase dysphagia (due to issues evaluation noted R10 was at a food or fluids. Were made for puree bites thorough mastication bites before taking another g, single sips, alternate ids. The report indicated all did be required to determine if | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
|--|--|---|--------------------|---|--|------------|
| | | 245090 | B. WING | | | 09/28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, 27 BRAND AVENUE FARIBAULT, MN 550 | | 00/20/2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORREC | PLAN OF CORRECTION CTIVE ACTION SHOULD E NCED TO THE APPROPRI DEFICIENCY) | |
| F 805 | R10's nutritional state identified a risk fact diet. No analysis of completed. R10's care plan dat nutritional alteration meals; had diet res [National Dysphaging ground or are minor pieces, they are more and could have req directed to monitor, physician as needes swallowing problem. R10's undated nursincluded mechanical statements. Speech ther all meats ground, ufor preference." R10's Oral/Dental Eindicated R10 had for the problem of the problem. It was not been all meats ground, ufor preference." | ppriate for diet upgrade. atus CAA dated 4/10/20, or of a mechanically altered f this risk factor was atus 4/1/20, included, risk for a related to coughing during trictions which included NDD2 a Diet, level 2- meats are to be and no larger than 1/4 inch bist, with some cohesion] diet uested puree. Staff were document, and report to the d for signs and symptoms of | F 8 | 05 | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING | | COMPLETED | | | | |
|--|--|--|---------------------|--|----------|----------------------------|
| | | 245090 | B. WING _ | | 09 | / 28/2020 |
| | | | | STREET ADDRESS, CITY, STATE, ZIP COL 27 BRAND AVENUE FARIBAULT, MN 55021 | | |
| PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 805 | nor did anyone bring R10's lunch tray tict texture and to prove potato salad, no ravelettuce." When interviewed aide (DA)-A stated mechanical soft die with ground meat, she normally does. When interviewed (CK)-A stated, a meground meat, no brown cook is the person correct diet is served. When interviewed stated R10 does counaware R10 did not stated if someone is should go get a nur in the dining room. When interviewed stated she normally today got a regular grilling them. R10 dentures, but forgo have to remind her them. At 1:39 p.m. asked her if she was with the sale of th | ket included, "Mechanical soft ide ground grilled hamburger, w veggies, beans, shredded on 9/25/20, at 1:06 p.m. dietary residents who require a et should have been provided R10 coughing is something while eating. on 9/25/20, at 1:12 p.m. cook echanical soft diet should have read or hard vegetables. The responsible to ensure the responsible to ensure the red. on 9/25/20, at 1:21 p.m. NA-Fough at meals, she was of have dentures in. NA-F so coughing like that, they rese to assess if no nurse was on 9/25/20, at 1:34 p.m. R10 y gets a ground burger, but whole burger as they were stated she normally wore her to put them in or help her with R10 was coughing and NA-H | | 05 | | |
| | wished for an upgra | ets could be upgraded if they ade, but would have to sign a statement. R10 did not have | | | | |

| | OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | COM | E SURVEY IPLETED |
|--------------------------|--|--|--------------------|------|---|------------|----------------------------|
| | | 245090 | B. WING | | | | C 28/2020 |
| | PROVIDER OR SUPPLIER | | | 27 E | EET ADDRESS, CITY, STATE, ZIP CODE BRAND AVENUE RIBAULT, MN 55021 | , <u> </u> | 20,2020 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 805 | a risk versus benef she given the risks a regular hamburge. When interviewed of Cook-A stated they who had signed a risk for a diet upgrade, they can provide it. these. R10 should ground meat diet as hamburger. R10's Diet Requisit and dated 3/31/20, speech therapy and Mechanical Soft/Griconsistency and papureed food if desir When interviewed or registered dietician coughing during a risk beand a form signed. When interviewed of the DON, food servit the apple of the pool of the p | its statement signed nor was of choking when provided with er today. In 9/25/20, at 3:08 p.m. In have a file of each resident isk versus benefits statement then if they ask for an upgrade R10 did not have one of have been provided the sordered and not a regular It ion Form provided by Cook-A had been completed by dindicated R10 was to have a round Meat NDD2 diet attent could downgrade to red. In 9/28/20, at 10:21 p.m. the (RD) stated if a resident were meal it should be reported to rice director and speech not been done for R10. The rovide an upgraded texture leing explained to the resident to 19/28/20, at 2:37 p.m. the ted it is important to provide ture for residents with its. A nurse should be notified ghing. | F 8 | 805 | | | |
| | cognitive impairme | dated 9/4/20, indicated no nt with diagnoses including, he MDS noted R5 had | | | | | |

| | TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | COM | (X3) DATE SURVEY COMPLETED C | | |
|--------------------------|--|--|---------------------|--|-------|----------------------------|
| | | 245090 | B. WING _ | | | 28/2020 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| | swallowing medicate period. The MDS for oversite, set up whe altered textures. R5's Speech Thera indicated diagnoses and oral phase dysindicated R5 had more than the evaluation had dentures that did nowithout dentures, R consistency solids a Advanced. R5 was of materials into the penetration (passagand/or asphyxiation R5's Care Assessmedated 1/20/20, indicated 1/20/20, i | ions during meals or when ions during the assessment urther indicated supervision, en eating and mechanically by Evaluation dated 1/25/19, so of cerebral infarction (stroke) phagia. The evaluation further issing teeth, and at the time of full upper and partial lower of fit. The evaluation indicated 5 could not chew regular and recommended Dysphagia at risk of aspiration (passage e vocal cords), laryngeal ge of materials into the larynx, in ent Area Worksheet (CAA) eated R5 required a didet. There was no analysis a noted to proceed to care | F 80 | 05 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
|--|---|--|---------------------|--|------------------------------|----------------------------|
| | | 245090 | B. WING _ | | 09 | /28/2020 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 27 BRAND AVENUE FARIBAULT, MN 55021 | - | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| F 805 | R5's Care guide for and independent in from MDS 9/4/20, 0 physician order and R5's lunch tray tick Dysphagia Advance further directed to phamburger on bun, vegetables, backed lettuce, soft ice cre During an observat R5 sat alone at a tawhile she ate her myhole hamburger vegetables area including nurses stopped to see why p.m. R5 was obserfor someone get a having a seizure. Sof the dining room. When interviewed stated R5 should heans, potato salar should not have has have been ground potato chips or who when interviewed stated she has occurspells," and has not when interviewed of cook-A stated the formal stated the | r staff indicated a regular diet dining room which is different CAA 1/20/20, Medical Record, d care plan. et included a diet order for ed diet (NDD3). The tray ticket provide chopped, grilled potato salad, no raw d beans, no bacon, shredded am and milk. ion on 9/25/20, at 12:50 p.m. able and was noted to cough heal. R5's plate contained a with a wedge of lettuce that on a bun and potato chips. Is staff throughout the dining ing and dietary, but no one of R5 was coughing. At 12:52 wed to be shaking and asked nurse because she was taff came and brought R5 out on 9/25/20, at 1:06 p.m. DA-A ave received ground meat, d, soft cooked vegetables. R5 d a bun, the burger should and should not have received be leaf lettuce. | F 80 | 05 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | C (X3) DATE SURVEY | |
|---|--|---|---|----|---|--------------------|----------------------------|
| | | 245090 | B. WING | | | | 28/2020 |
| NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC | | | | 27 | REET ADDRESS, CITY, STATE, ZIP CODE BRAND AVENUE RIBAULT, MN 55021 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 805 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 59 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. | | F8 | 05 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--|---|---|-------------------------------|--|--|
| | | 245090 | B. WING _ | | 09 | C / 28/2020 | | |
| NAME OF PROVIDER OR SUPPLIER PLEASANT MANOR LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 | (EACH CORRECTIVE ACTION SHO | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | |
| F 805 | The National Dysph Dysphagia Mechan Level 1 are allowed foods may be groun no larger than one is should be easy to o Moistened ground of fish. Moist ground with gravy or sauce pureed bread mixes and slurred breads thickness of products. Vegetable vegetables. Vegetable | ge 60 nagia Diet indicated NDD2 as ically Altered. All foods on . Meats and other select and or minced into small pieces forth inch. All food items thew. Meats should be or cooked meat, poultry, or or tender meat may be served and a Breads products can be as, moistened bread crumbs that are gelled through entire at and to avoid all other bread as should be soft, well-cooked ables should be less than 1/2 easily mashed with a fork. | F 80 |)5 | | | | |