DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 8, 2022

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

RE: CCN: 245090
Cycle Start Date: January 6, 2022

Dear Administrator:

On January 25, 2022, we notified you a remedy was imposed. On February 7, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 14, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 9, 2022 be discontinued as of January 14, 2022. (42 CFR 488.417 (b))

As we notified you in our letter of January 25, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 6, 2022. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 8, 2022

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

Re: Reinspection Results
Event ID: MKGW12

Dear Administrator:

On February 7, 2022 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 January 6, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
January 25, 2022

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

RE: CCN: 245090
Cycle Start Date: January 6, 2022

Dear Administrator:

On January 6, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On January 6, 2022, the situation of immediate jeopardy to potential health and safety cited at F0689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 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 February 9, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 9, 2022 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 9, 2022 (42 CFR 488.417 (b)).

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Pleasant Manor Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 6, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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, Licensing and Certification Program 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 July 6, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 25, 2022

Administrator
Pleasant Manor LLC
27 Brand Avenue
Faribault, MN 55021

Re: State Nursing Home Licensing Orders
Event ID: MKGW11

Dear Administrator:

The above facility was surveyed on December 30, 2021 through January 6, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 01/06/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/30/21 to 1/6/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5090094C (MN79583), with a deficiency cited at F689. The survey resulted in an Immediate Jeopardy (IJ) at F689 when the facility failed to provide appropriate texture modifications for R1 who required altered textures. The facility fed R1 a sandwich and regular pizza and vegetables. Additionally, staff were not aware of speech language pathology swallowing strategies and supervision recommendations which resulted in R1's death 12/12/21. The immediate jeopardy began on 12/9/21 and was removed on 1/6/22. The above findings constituted substandard quality of care, and an extended survey was conducted from 1/4/22 to 1/6/22. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/28/2022

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prepare food in accordance with residents needs for 1 of 3 residents (R1), reviewed for diet modifications. R1 received regular textured diet which resulted in hospitalization and death. This resulted in an immediate jeopardy (IJ) situation for R1. The IJ began on 12/9/21, when the facility failed to provide appropriate texture modifications for R1 who required altered textures. The facility fed R1 a sandwich and regular pizza and vegetables. Additionally, staff were not aware of speech language pathology swallowing strategies and supervision recommendations which resulted in R1's death 12/12/21. The director of nursing (DON) and administrator were notified of the immediate jeopardy on 1/4/22, at 11:45 a.m.. The immediate jeopardy was removed on 1/6/22, at 1:33 p.m., but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: R1's Face Sheet indicated R1 admitted on	F 689	PLAN OF CORRECTION 01/25/2022 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R1 expired. How the facility will identify other residents having the potential to be affected by the same deficient practice: Audit completed on all residents' care plans and orders to ensure correct diet orders and correct supervision. Ensured that all residents have the appropriate care plan. Therapy, Nursing and Dietary did collaborate to ensure software, forms and verbiage is standardized across all disciplines. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The process related to entering and modifying orders was reviewed. The facility changed the forms and dataflow so all three disciplines (therapy, dietary, and nursing) are using similar language,	1/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245090	A. BUILDING _____ B. WING _____	C 01/06/2022

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

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F 689	Continued From page 2 12/9/21 and discharged on 12/11/21. R1's diagnoses included dysphagia (swallowing difficulties) following cerebral infraction, hemiplegia and hemiparesis (loss of strength or paralysis on one side of the body). R1's Speech Language Pathology (SLP) hospital discharge summary dated 12/9/21, indicated R1 had oral pocketing/residue so mechanical soft diet with thin liquids would be the most appropriate diet. R1 had precautions to slow down, small bites/sips, need for intermittent supervision to cue for clearing oral cavity and monitor for signs of aspiration. R1's Physician Orders in the electronic health record dated 12/9/21 indicated: -regular diet, regular texture, regular (thin) consistency -regular diet, mechanical soft texture, regular (thin) consistency. R1's SLP Discharge Summary dated 12/9/21, indicated R1 was safest on national dysphagia diet 2 (NDDII) solids. R1 received SLP for dysphagia following a cerebral infraction. Therapy Precautions included upright positioning during all meals, reduced bolus size, reduced rate of intake, frequent alternation of liquids/solids, check for left side for pocketing via lingual sweep/re-swallow. R1's posture impacted function of swallow. The facility SLP Therapy Recommendations for Diet Textures and Strategies dated 12/9/21, indicated national dysphagia diet 2 (NDDII) diet order (dysphagia mechanically altered) and thin liquids with a cup and straw. R1 required occasional supervision (no defined definition). R1	F 689	including diet and supervision level. The process for ensuring care plans/48 hour care plans are updated per Speech Language Pathologist recommendations/orders and communication to all staff was reviewed. Revision of the process includes ensuring the communication of patient supervision level, if anything other than none, on the order, care plan and group sheets. The process for ensuring meal trays, including correct diet was reviewed and revised. Tray cards have been updated to prominently show resident diet. Diet Order Guidelines sheet were updated and placed on every tray cart and in the dining room for quick reference for staff. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Staff (Director of Nursing, Nurse Manager, Health Information Manager) responsible for order entry were reeducated on process including diet orders. Nursing dietary communication form was revised to have the same terminology as the diet order (see Diet Requisition Form). Staff (Director of Nursing and Nurse Manager) responsible for ensuring care plans are updated per SLP recommendations were reeducated on process to update and communicate to staff. Therapy Recommendations for Diet Textures and Strategies will not change a dietary order until verified by a physician and communicated by the use of the Dietary Requisition Form. Therapy director, Director of Nursing, nurse manager,	

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

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F 689	Continued From page 3 was to implement strategies and caregivers were to cue R1 to use strategies. R1's strategies included: R1 was to sit upright while eating/drinking, eat/drink at a slow pace, take small bites/sips, clear mouth before each bite, clear left side for pocketing, use lingual sweep/finger sweep and re-swallow and take a sip every three bites. R1's Clinical Nutrition Evaluation dated 12/10/21, indicated chewing difficulty, limited mobility and hemiplegia. R1 required safe swallow strategies, ate in his room and was able to feed himself. R1's provider Progress Note (PN) dated 12/10/21, indicated R1 was to work with SLP to minimize aspiration risk for dysphagia from his stroke. R1's PN dated 12/10/21, at 1:20 p.m. indicated an order for NDDII diet. R1 had safe swallow strategies and straws were recommend by speech therapy. R1's PN dated 12/11/21, at 10:04 p.m. indicated R1 was sent to the emergency room (ER) due to hematuria, emesis, and diarrhea. R1's Hospital Discharge Summary dated 12/12/21, indicated R1 was admitted from a nursing home for increased cough, and fever. R1 was post stroke that resulted in significant dysphagia. The hospital record indicated R1 was apparently fed a regular diet that resulted in a cough and onset of fever. Initial chest x-rays showed bilateral atelectasis and possible infiltrates with small pleural effusion. R1 died on 12/12/21.	F 689	Culinary Director and Health Information Manager were educated by the Regional Education Consultant, in person, on the flow of orders being entered into our EMR, PointClickCare. Staff (licensed nurses, TMAs, and CNAs) responsible for providing supervision to residents while eating were reeducated on definitions of levels of supervision and requirements. Diet Texture Education was provided via Google Forms, or physical copy, made up of educational material and a quiz sent to IDT team including all administrative staff, licensed nurses, TMAs, CNAs, NAITs, including support services from the National Guard and agency staff, culinary cook and aides, therapeutic recreation, therapy, and maintenance. Results were sent back to the administrator showing who completed the education and their quiz. Reeducation was provided by administrator or designee for staff that provided incorrect answers to quiz. Administrator or designee will ensure education is sustained by conducting verbal knowledge checks. Audits began on all residents requiring modified diets 5x weekly x 4 weeks and monthly x 2 months to ensure that diet orders are correct and only food items that meet the modified diet are provided to the resident. Audits began on all resident care plans who are requiring modified diets or supervision while eating 5x weekly x 4 weeks and monthly x 2 months to ensure that care plans accurately reflect SLP recommendations. Audits began on all residents requiring supervision while eating 5x weekly x 4	

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F 689	Continued From page 4 The Minnesota Cause of Death Record indicated R1 died on 12/12/21 from complications of sepsis due to suspected aspiration due to dysphagia. R1's care plan dated 12/15/21, indicated national dysphagia diet order level 2 (NDDII). There was no indication of need for supervision. During an interview on 12/30/21, at 10:08 a.m. family member (FM)-A stated R1 was placed on a dysphagia diet after his stroke. FM-A stated when R1 admitted he pinned documentation of R1's diet on a billboard to inform staff then left to complete some admission paperwork. FM-A stated he returned to R1's room on 12/9/21, around 2:30 p.m. and found R1 ate ½ of his meal which consisted of a ham and cheese sandwich, puffcorn, and peaches. FM-A stated the ham was not ground and the bread was regular pieces of bread with packets of mayo next it. FM-A stated when he saw his dad was given the wrong meal, he got mad, pulled the meal away from him and put the meal on R1's nightstand. FM-A stated R1 was unsupervised and should have been since he was on altered textures with swallowing difficulties following a stroke. FM-A stated on 12/10/21, FM-B reported to FM-A that R1 ate regular pizza and had sliced green vegetables served to him without supervision. FM-A stated on 12/11/21, FM-A received a call that R1 was vomiting and sent to the hospital. FM-A stated the hospital told him R1 appeared to aspirate more than once which caused aspiration pneumonia, made R1 be septic, which lead to R1's death. FM-A stated R1 death was not expected, out of the blue and should not have happened. During an interview on 12/30/21, at 11:25 a.m. registered nurse (RN)-A stated he worked with R1	F 689	weeks and monthly x 2 months to ensure that residents are receiving the recommended level of supervision per care plan. The results of the audits completed will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the regular audits. The date that each deficiency was corrected: 1/5/22	

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F 689	Continued From page 5	F 689		

for multiple shifts. RN-A indicated staff would set up R1's tray, drop off his meals and ask if he wanted anything. RN-A stated R1 did not require assistance, or supervision at meals and ate alone in his room. RN-A stated R1 was at the facility for two days and was mostly in bed. RN-A stated on 12/11/21, before R1 was sent to the hospital R1 stated he did not feel good, felt feverish, and threw up multiple times after he ate. RN-A stated R1 received normal textured foods at meals.

During an interview on 12/20/21, at 1:09 p.m. nursing assistant (NA)-D stated on 12/10/21, she went into R1's room around 7:30 or 8 p.m. and saw NA-C was in there. NA-D stated NA-C told her every time R1 laid down his head he would "projectile vomit."

During an interview on 12/30/21, at 1:41 a.m. NA-A stated R1 was independent and ate alone in his room.

During an interview on 12/30/21, at 1:44 p.m. NA-C stated on 12/11/21, NA-C brought R1 his tray around 5:00 p.m. NA-C stated R1 was not on an altered texture and ate independently. NA-C was not aware of the need to provide swallow strategies for R1. NA-C stated around 6:00 p.m. she checked on R1 whom ate ½ of his normal textured meal. NA-C further stated around 7:00 p.m. NA-C found R1 laying downward and was "vomiting hard." NA-C stated at first the vomit was normal vomit but turned into bile and chunks. NA-C stated she raised the top of R1's bed to help with the vomiting and he stopped puking. NA-C stated R1 continued to dry heave like he was going to puke but nothing came out. NA-C further stated each time R1 dry heaved or vomited "fluids came out of all ends". R1 could

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F 689	Continued From page 6 talk, was alert but had his eyes closed. NA-C stated each time trained medication aide (TMA)-A and she tried to lay him down he would start to dry heave again. During an interview on 12/30/21, at 3:08 p.m. SLP- C stated occasional supervision means supervision to follow general strategies at meals and someone was around to give cues and reminders to a resident. During an interview on 12/30/21, at 3:37 p.m. NA-E stated on 12/11/21, he remembered R1 had thrown up all over and was dry heaving before he went to the hospital later that evening. During an interview on 1/3/22, at 9:13 a.m. the food service director (FSD) stated a mechanical soft, NDDII facility diet texture was to have ground meat, no lettuce, nothing raw, and no bread. FSD further stated everything should be cooked soft and mashable. During an interview on 1/3/22, at 10:12 a.m. the director of nursing (DON) stated supervision was a "gray area" and there was no definition as each resident had different needs. DON provided an example that a resident with a stroke would need more supervision then a resident with another medical condition. The DON verified the facility would go off SLP recommendations which should be place on a resident's care sheet and care plan. During an interview on 1/3/22, at 10:26 a.m. the director of rehab (DOR) stated SLP-A filled out recommendations for R1 on 12/9/21. DOR stated R1 recommendations included mechanical soft (NDDII) texture, occasional supervision which	F 689		

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F 689	Continued From page 7 included additional safe swallow strategies staff were to provide at meals. During an interview on 1/3/22, at 11:40 a.m. the DOR stated there was no policy or definition of the different levels of supervision. During an interview on 1/3/22, at 12:12 a.m. NA-F stated she would find if a resident required assistance from the nursing care sheet. NA-F stated she did not know what direct supervision meant. During an interview on 1/3/22, at 12:21 p.m. (TMA)-A stated on 12/11/21, NA-C asked TMA-A for help. NA-C stated later in the evening R1 started to throw up and would not stop vomiting. NA-C stated R1 threw up his dinner. NA-C further stated she was not aware of what occasional supervision was. TMA-A stated occasional supervision was not a term usually used and was used to just supervision. TMA-A was not aware of any recent diet texture education. During an interview on 1/3/21, at 2:54 p.m. RN-A stated R1 did not need any supervision or assistance at meals. During an interview on 1/4/22, at 10:19 a.m. FSD verified R1 had two diet orders in their electric medical record and stated this could be confusing for staff to understand what diet R1 was on. The FSD stated anytime a resident has a mechanical diet the electronic health record should indicate in the directions section of the orders the national dysphagia diet level. The facility Diet Manual and Diet Orders policy undated, indicated diet changes should be made	F 689		

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F 689	Continued From page 8 in a patient's medical record. The culinary director or designee will oversee updating the tray card system. At no time may texture upgrades be made unless ordered by the physician and/or SLP. The facility Diet Orders Guidelines dated 5/2020, indicated mechanical soft (NDD2) diet guidelines include foods that are mechanically altered by blending, ground or mashing so they're easy to chew and swallow. The facility Level 2: Dysphagia Mechanically Altered diet undated indicated breads should be pureed bread mixes, pre-gelled or slurries breads that are gelled through entire thickness and to avoid all others. Meats should be moistened ground meat, poultry, or fish. Moist meat must be served with gravy or sauce. The diet should avoid dry meat, cheese slices, sandwiches, and pizza. Vegetables should be soft, well cooked, and easily mashed with a fork. The immediate jeopardy that began on 12/9/21, was removed on 1/6/22, when the facility developed and implemented interventions to ensure SLP orders and recommendations were implemented. The facility started completed audits on all residents' care plans, and diet orders; Therapy, nursing and dietary collaborated to ensure software, forms and verbiage was standardized. The process to enter modified diet orders was reviewed; the process to ensure care plans reflected SLP recommendations and were communicated to staff was reviewed. Tray tickets were updated to show resident diet and diet order guidelines were placed on every tray cart for staff reference. Education was provided on diet order entry, communication between dietary and	F 689		

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F 689	Continued From page 9 nursing, the process to communicate and update SLP recommendations and the definition of supervision levels and diet textures. Facility staff were able to identify education was completed and systems were put into place. Documentation of resident's care plans, diet orders, tray tickets were reviewed. Observations were made of meals service to ensure the facility implemented their plan of correction.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/30/21 to 1/6/22,, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5090094C/MN79583 with a licensing order issued at tag 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to prepare food in accordance with residents needs for 1 of 3 residents (R1), reviewed for diet modifications. R1 received regular textured diet which resulted in hospitalization and death. The immediate jeopardy (IJ) began on 12/9/21, when the facility failed to provide appropriate texture modifications for R1 who required altered textures. The facility fed R1 a sandwich and regular pizza and vegetables. Additionally, staff were not aware of speech language pathology swallowing strategies and supervision recommendations which resulted in R1's death	2 830	PLAN OF CORRECTION 01/25/2022 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R1 expired. How the facility will identify other residents having the potential to be affected by the same deficient practice: Audit completed on all residents' care plans and orders to ensure correct diet orders and correct supervision. Ensured that all residents have the appropriate	1/7/22

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2 830	Continued From page 3 12/12/21. The director of nursing (DON) and administrator were notified of the immediate jeopardy on 1/4/22, at 11:45 a.m.. The immediate jeopardy was removed on 1/6/22, at 1:33 p.m., but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: R1's Face Sheet indicated R1 admitted on 12/9/21 and discharged on 12/11/21. R1's diagnoses included dysphagia (swallowing difficulties) following cerebral infraction, hemiplegia and hemiparesis (loss of strength or paralysis on one side of the body). R1's Speech Language Pathology (SLP) hospital discharge summary dated 12/9/21, indicated R1 had oral pocketing/residue so mechanical soft diet with thin liquids would be the most appropriate diet. R1 had precautions to slow down, small bites/sips, need for intermittent supervision to cue for clearing oral cavity and monitor for signs of aspiration. R1's Physician Orders in the electronic health record dated 12/9/21 indicated: -regular diet, regular texture, regular (thin) consistency -regular diet, mechanical soft texture, regular (thin) consistency. R1's SLP Discharge Summary dated 12/9/21, indicated R1 was safest on national dysphagia diet 2 (NDDII) solids. R1 received SLP for dysphagia following a cerebral infraction. Therapy Precautions included upright positioning during all meals, reduced bolus size, reduced rate of	2 830	care plan. Therapy, Nursing and Dietary did collaborate to ensure software, forms and verbiage is standardized across all disciplines. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The process related to entering and modifying orders was reviewed. The facility changed the forms and dataflow so all three disciplines (therapy, dietary, and nursing) are using similar language, including diet and supervision level. The process for ensuring care plans/48 hour care plans are updated per Speech Language Pathologist recommendations/orders and communication to all staff was reviewed. Revision of the process includes ensuring the communication of patient supervision level, if anything other than none, on the order, care plan and group sheets. The process for ensuring meal trays, including correct diet was reviewed and revised. Tray cards have been updated to prominently show resident diet. Diet Order Guidelines sheet were updated and placed on every tray cart and in the dining room for quick reference for staff. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Staff (Director of Nursing, Nurse Manager, Health Information Manager) responsible for order entry were reeducated on process including diet orders. Nursing dietary communication form was revised to have the same terminology as the diet order (see Diet Requisition Form). Staff	

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2 830	Continued From page 4 intake, frequent alternation of liquids/solids, check for left side for pocketing via lingual sweep/re-swallow. R1's posture impacted function of swallow. The facility SLP Therapy Recommendations for Diet Textures and Strategies dated 12/9/21, indicated national dysphagia diet 2 (NDDII) diet order (dysphagia mechanically altered) and thin liquids with a cup and straw. R1 required occasional supervision (no defined definition). R1 was to implement strategies and caregivers were to cue R1 to use strategies. R1 strategies included: R1 was to sit upright while eating/drinking, eat/drink at a slow pace, take small bites/sips, clear mouth before each bite, clear left side for pocketing, use lingual sweep/finger sweep and re-swallow and take a sip every three bites. R1's Clinical Nutrition Evaluation dated 12/10/21, indicated chewing difficulty, limited mobility and hemiplegia. R1 required safe swallow strategies, ate in his room and was able to feed himself. R1's provider PN dated 12/10/21, indicated R1 was to work with SLP to minimize aspiration risk for dysphagia from his stroke. R1's Progress Note (PN) dated 12/10/21, at 1:20 p.m. indicated an order for NDDII diet. R1 had safe swallow strategies and straws were recommend by speech therapy. R1's PN dated 12/11/21, at 10:04 p.m. indicated R1 was sent to the Emergency Room (ER) due to hematuria, emesis, and diarrhea. R1's Hospital Discharge Summary dated 12/12/21, indicated R1 was admitted from a	2 830	(Director of Nursing and Nurse Manager) responsible for ensuring care plans are updated per SLP recommendations were reeducated on process to update and communicate to staff. Therapy Recommendations for Diet Textures and Strategies will not change a dietary order until verified by a physician and communicated by the use of the Dietary Requisition Form. Therapy director, Director of Nursing, nurse manager, Culinary Director and Health Information Manager were educated by the Regional Education Consultant, in person, on the flow of orders being entered into our EMR, PointClickCare. Staff (licensed nurses, TMAs, and CNAs) responsible for providing supervision to residents while eating were reeducated on definitions of levels of supervision and requirements. Diet Texture Education was provided via Google Forms, or physical copy, made up of educational material and a quiz sent to IDT team including all administrative staff, licensed nurses, TMAs, CNAs, NAITs, including support services from the National Guard and agency staff, culinary cook and aides, therapeutic recreation, therapy, and maintenance. Results were sent back to the administrator showing who completed the education and their quiz. Reeducation was provided by administrator or designee for staff that provided incorrect answers to quiz. Administrator or designee will ensure education is sustained by conducting verbal knowledge checks. Audits began on all residents requiring modified diets 5x weekly x 4 weeks and monthly x 2 months to ensure that diet	

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PLEASANT MANOR LLC	27 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 nursing home for increased cough, and fever. R1 was post stroke that resulted in significant dysphagia. The hospital record indicated R1 was apparently fed a regular diet that resulted in a cough and onset of fever. Initial chest x-rays showed bilateral atelectasis and possible infiltrates with small pleural effusion. R1 died on 12/12/21. The Minnesota Cause of Death Record indicated R1 died on 12/12/21 from complications of sepsis due to suspected aspiration due to dysphagia. R1's care plan dated 12/15/21, indicated national dysphagia diet order level 2 (NDDII). There was no indication of need for supervision. During an interview on 12/30/21, at 10:08 a.m. family member (FM)-A stated R1 was placed on a dysphagia diet after his stroke. FM-A stated when R1 admitted he pinned documentation of R1's diet on a billboard to inform staff then left to complete some admission paperwork. FM-A stated he returned to R1's room on 12/9/21, around 2:30 p.m. and found R1 ate ½ of his meal which consisted of a ham and cheese sandwich, puffcorn, and peaches. FM-A stated the ham was not ground and the bread was regular pieces of bread with packets of mayo next it. FM-A stated when he saw his dad was given the wrong meal, he got mad, pulled the meal away from him and put the meal on R1's nightstand. FM-A stated R1 was unsupervised and should have been since he was on altered textures after with swallowing difficulties following a stroke. FM-A stated on 12/10/21, FM-B reported to FM-A that R1 ate regular pizza and had sliced green vegetables served to him without supervision. FM-A stated on 12/11/21, FM-A received a call that R1 was vomiting and sent to the hospital. FM-A stated the	2 830	orders are correct and only food items that meet the modified diet are provided to the resident. Audits began on all resident care plans who are requiring modified diets or supervision while eating 5x weekly x 4 weeks and monthly x 2 months to ensure that care plans accurately reflect SLP recommendations. Audits began on all residents requiring supervision while eating 5x weekly x 4 weeks and monthly x 2 months to ensure that residents are receiving the recommended level of supervision per care plan. The results of the audits completed will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the regular audits. The date that each deficiency was corrected: 1/5/22	

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2 830	Continued From page 6	2 830		

hospital told him R1 appeared to aspirate more than once which caused aspiration pneumonia, made R1 be septic, which lead to R1's death. FM-A stated R1 death was not expected, out of the blue and should not have happened.

During an interview on 12/30/21, at 11:25 a.m. Registered nurse (RN)-A stated he worked with R1 for multiple shifts. RN-A indicated staff would set up R1's tray, drop off his meals and ask if he wanted anything. RN-A stated R1 did not require assistance, or supervision at meals and ate alone in his room. RN-A stated R1 was at the facility for two days and was mostly in bed. RN-A stated on 12/11/21, before R1 was sent to the hospital R1 stated he didn't feel good, felt feverish, and threw up multiple times after he ate. RN-A stated R1 received normal textured foods at meals.

During an interview on 12/20/21, at 1:09 p.m. nursing assistant (NA)-D stated on 12/10/21, she went into R1's room around 7:30 or 8 p.m. and saw NA-C was in there. NA-D stated NA-C told her every time R1 laid down his head he would "projectile vomit."

During an interview on 12/30/21, at 1:41 a.m. NA-A stated R1 was independent and ate alone in his room.

During an interview on 12/30/21, at 1:44 p.m. NA-C stated on 12/11/21, NA-C brought R1 his tray around 5:00 p.m. NA-C stated R1 was not on an altered texture and ate independently. NA-C was not aware of the need to provide swallow strategies for R1. NA-C stated around 6:00 p.m. she checked on R1 whom ate ½ of his normal textured meal. NA-C further stated around 7:00 p.m. NA-C found R1 laying downward and was "vomiting hard." NA-C stated at first the vomit

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2 830	Continued From page 7 was normal vomit but turned into bile and chunks. NA-C stated she raised the top of R1's bed to help with the vomiting and he stopped puking. NA-C stated R1 continued to dry heave like he was going to puke but nothing came out. NA-C further stated each time R1 dry heaved or vomited "fluids came out of all ends". R1 could talk, was alert but had his eyes closed. NA-C stated each time trained medication aide (TMA)-A and she tried to lay him down he would start to dry heave again. During an interview on 12/30/21, at 3:08 p.m. SLP- C stated occasional supervision means supervision to follow general strategies at meals and someone was around to give cues and reminders to a resident. During an interview on 12/30/21, at 3:37 p.m. NA-E stated on 12/11/21, he remembered R1 had thrown up all over and was dry heaving before he went to the hospital later that evening. During an interview on 1/3/22, at 9:13 a.m. the food service director (FSD) stated a mechanical soft, NDDII facility diet texture was to have ground meat, no lettuce, nothing raw, and no bread. FSD further stated everything should be cooked soft and mashable. During an interview on 1/3/22, at 10:12 a.m. the director of nursing (DON) stated supervision was a "gray area" and there was no definition as each resident had different needs. DON provided an example that a resident with a stroke would need more supervision then a resident with another medical condition. The DON verified the facility would go off SLP recommendations which should be place on a resident's care sheet and care plan.	2 830		

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2 830	Continued From page 8 During an interview on 1/3/22, at 10:26 a.m. the director of rehab (DOR) stated SLP-A filled out recommendations for R1 on 12/9/21. DOR stated R1 recommendations included mechanical soft (NDDII) texture, occasional supervision which included additional safe swallow strategies staff were to provide at meals. During an interview on 1/3/22, at 11:40 a.m. the director of rehab (DOR) stated there was no policy or definition of the different levels of supervision. During an interview on 1/3/22, at 12:12 a.m. NA-F stated she would find if a resident required assistance from the nursing care sheet. NA-F stated she did not know what direct supervision meant. During an interview on 1/3/22, at 12:21 p.m. trained medical aide (TMA)-A stated on 12/11/21, NA-C asked TMA-A for help. NA-C stated later in the evening R1 started to throw up and would not stop vomiting. NA-C stated R1 threw up his dinner. NA-C further stated she was not aware of what occasional supervision was. TMA-A stated occasional supervision was not a term usually used and was used to just supervision. TMA-A was not aware of any recent diet texture education. During an interview on 1/3/21, at 2:54 p.m. RN-A stated R1 did not need any supervision or assistance at meals. During an interview on 1/4/22, at 10:19 a.m. FSD verified R1 had two diet orders in their electric medical record and stated this could be confusing for staff to understand what diet R1 was on. The	2 830		

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2 830	Continued From page 9 FSD stated anytime a resident has a mechanical diet the electronic health record should indicate in the directions section of the orders the national dysphagia diet level. The facility Diet Manual and Diet Orders policy undated, indicated diet changes should be made in a patient's medical record. The culinary director or designee will oversee updating the tray card system. At no time may texture upgrades be made unless ordered by the physician and/or SLP. The facility Diet Orders Guidelines dated 5/2020, indicated mechanical soft (NDD2) diet guidelines include foods that are mechanically altered by blending, ground or mashing so they're easy to chew and swallow. The facility Level 2: Dysphagia Mechanically Altered diet undated indicated breads should be pureed bread mixes, pre-gelled or slurries breads that are gelled through entire thickness and to avoid all others. Meats should be moistened ground meat, poultry, or fish. Moist meat must be served with gravy or sauce. The diet should avoid dry meat, cheese slices, sandwiches, and pizza. Vegetables should be soft, well cooked, and easily mashed with a fork. The immediate jeopardy that began on 12/9/21, was removed on 1/6/22, when the facility developed and implemented interventions to ensure SLP orders and recommendations were implemented. The facility started completed audits on all residents' care plans, and diet orders; Therapy, nursing and dietary collaborated to ensure software, forms and verbiage was standardized. The process to enter modified diet orders was reviewed; the process to ensure care	2 830		

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2 830	Continued From page 10 plans reflected SLP recommendations and were communicated to staff was reviewed. Tray tickets were updated to show resident diet and diet order guidelines were placed on every tray cart for staff reference. Education was provided on diet order entry, communication between dietary and nursing, the process to communicate and update SLP recommendations and the definition of supervision levels and diet textures. Facility staff were able to identify education was completed and systems were put into place. Documentation of resident's care plans, diet orders, tray tickets were reviewed. Observations were made of meals service to ensure the facility implemented their plan of correction. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 830		