DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 6, 2021

Administrator
Madonna Towers Of Rochester Inc
4001 19th Avenue Northwest
Rochester, MN 55901

RE: CCN: 245153
Cycle Start Date: October 23, 2020

Dear Administrator:

On November 17, 2020, we notified you a remedy was imposed. On December 30, 2020 the Minnesota Department(s) 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 December 4, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 2, 2020 be discontinued as of December 4, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of November 17, 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), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 23, 2020. 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 6, 2021

Administrator
Madonna Towers Of Rochester Inc
4001 19th Avenue Northwest
Rochester, MN 55901

Re: Reinspection Results
Event ID: 243112

Dear Administrator:

On December 30, 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 October 23, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

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Electronically Submitted
November 17, 2020

Administrator
Madonna Towers Of Rochester Inc
4001 19th Avenue Northwest
Rochester, MN 55901

RE: CCN: 245153
Cycle Start Date: October 23, 2020

Dear Administrator:

On October 23, 2020, 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 October 22, 2020, the situation of immediate jeopardy to potential health and safety cited at F0684 was removed. However, continued non-compliance remains at the lower scope and severity of G.

On October 22, 2020, the situation of immediate jeopardy to potential health and safety cited at F0760 was removed. However, continued non-compliance remains at the lower scope and severity of G.

On October 22, 2020, the situation of immediate jeopardy to potential health and safety cited at F0806 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 December 2, 2020.

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 December 2, 2020, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 2, 2020, (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, Madonna Towers Of Rochester Inc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 23, 2020. 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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 April 23, 2021 (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 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER INC	**4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901**

(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 10/19 through 10/23/20 an abbreviated survey was completed at your facility to conduct complaint investigations. 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: H5153039C, with deficiencies cited at F755 and F760 H5153040C, with a deficiency at F684 H5153041C, with deficiencies cited at F585, F684, F688, F725, F755, F760, and F806 H5153044C, with deficiencies cited at F725, F755, and F760 The following complaints were NOT substantiated H5153042C H5153045C The survey resulted in the following Immediate Jeopardy's (IJ): 1) F684, when the facility failed to monitor/assess and identify respiratory change in condition that were associated with worsening deep vein thrombosis or pulmonary embolism and failed to immediately notify the physician in the setting of worsening respiratory distress. The IJ began on 9/25/20 and the immediacy was removed on 10/22/20. 2) F760, when the facility failed to ensure safe insulin administration that resulted in hypoclycemic events that required emergency life saving medication and hospitalization. The IJ	F 000		

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

Electronically Signed | 11/24/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 began 8/5/20, and the immediacy was removed on 10/22/20. 3) F806, when the facility failed to ensure a resident with a food allergy was not served the food with the allergen. The IJ began on 10/5/20, and the immediacy was removed on 10/22/20. The above findings constituted substandard quality of care, and an extended survey was conducted on 10/22 and 10/23/20. In addition, a COVID-19 Focused Infection Control survey was conducted on 10/23/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585		12/4/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MADONNA TOWERS OF ROCHESTER INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

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

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F 585	Continued From page 3 grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance,	F 585		

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F 585	Continued From page 4 and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure grievances related to long call-light wait times were acted upon for timely resolution for 6 of 6 residents (R7, R11, R12, R13, R14, R15) reviewed with ongoing complaints of assistance with care and call light response time. Findings include: During document review, 68 resident grievances were reviewed for time period 6/29/20 to 9/25/20. Of those 68 grievances, 18 were specific to the length of time it took staff to respond to resident call lights. During document review, resident council meeting minutes from 7/31/20, were reviewed. The meeting was attended by seven residents including R12, R13 and R15. Staff in attendance included social worker (SW)-A and the previous administrator. Minutes indicated residents voiced concern about call lights not being answered in a	F 585	R7 is no longer in the facility R11 was interviewed regarding call light response times and has no new concerns and will continue to be interviewed weekly regarding call light response time. R11 will be included in the weekly audit. R12 was interviewed regarding call light response times and has no new concerns and will continue to be interviewed weekly regarding call light response time. R11 will be included in the weekly audit. R13 was interviewed regarding call light response times and reported "it is somewhat better". R13 will be included in the weekly audit. R14 was interviewed regarding call light response times and has no new concerns and will continue to be interviewed weekly regarding call light response time. R11 will be included in the weekly audit. R15 was interviewed regarding call light response times and reported staff are better at acknowledging call lights and	

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F 585	Continued From page 5 timely manner, waiting too long for help, and concern if there was an emergency, it would take too long for staff to respond. The administrator reply read, "Shared what the team has been doing to help staff adjust to changes with Covid and shared that human resources is working hard to recruit staff." No other plan of action was identified in the minutes. During document review, resident council meeting minutes from 9/2020, (no specific date identified) were reviewed. The meeting was attended by 15 residents, including R11, R12, R13, R14 and R15. Staff in attendance included SW-A and the current administrator. Minutes indicated concerns about: more help needed on the floor, especially between 8:00 p.m. and 10:00 p.m.; call lights being turned off without being answered, call lights too long, residents sitting on the toilet too long, some staff won't help when they are supposed to. Minutes did not include a plan of action to address these concerns. R12's quarterly Minimum Data Set (MDS) assessment dated 8/18/20 indicated R12 was cognitively intact. During an interview on 10/19/20, at 10:58 a.m. R12 stated staff can't always come when she puts her call light on adding, "Nothing makes you feel more helpless at night and it's dark and no one comes." R12 stated, "They always put you on the toilet and say 'I'll be right back,' but they aren't right back." R12 stated, "I'll be right back are their famous words; they don't come right back." R12 stated, "I start out using my walker to get to the bathroom, but my kids say don't do that because I might fall." R12 stated long call lights are brought up at resident council meetings, but nothing gets done	F 585	returning more promptly. R15 will be included in the weekly audit. All residents who reside at Madonna Towers have the potential to be affected. "Concerns and Grievances" policy was reviewed and remains current. All staff to be educated on the Concerns and Grievances policy and the 4 Call system at the nursing staff trainings on 12/1 and 12/2. Project scope worksheet has been completed for the call light response time that includes the problem, the associate assigned to complete the PDCA and problem statement data based goal. 4 Call system implemented by 12/4/2020. Resident Council held on 11/19/2020. Audits of customer concerns and call light response time will be completed 3x/week for 4 weeks. Administrator/Designee is responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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about it. According to resident council meeting minutes, R12 attended the 7/31/20 and September 2020, meetings where call light response time concerns were raised.

R14's quarterly Minimum Data Set (MDS) assessment dated 10/6/20 indicated R14 was cognitively intact. During an interview on 10/19/20, at 1:13 p.m. R14 stated, "I can have my light on and wait as long as 30 minutes. I take prune juice and when I have to go, I have to go, so I try and go by myself. I'm having to do things on my own that I'm not supposed to do." R14 stated when long call lights and staffing were brought up at resident council, "It got a bit heated and the administrator backed away from it and changed the subject. He didn't want to talk about it." R14 stated, "It was evident we were weren't allowed to say much as he cut us off." R14 stated, "They say it's supposed to be our home, but it's far from it." According to resident council meeting minutes, R14 attended the September 2020, meeting where call light response time concerns were raised.

A grievance report dated 8/11/20, indicated R14's call light was on for 50 minutes, and looking back seven days, R14 had eight call lights over 20 minutes. Of those, three were over 30 minutes and of those, one was over 50 minutes. Grievance report follow-up indicated the administrator talked to R14 about her concerns. The administrator explained that ideally, there would be two people assigned to R14's hallway, but when staff call in, it was hard to replace them at the last minute. Actions: The DON will do education with staff about making sure they are cognizant of the length of call lights when they

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answer lights.

R13's quarterly Minimum Data Set (MDS) assessment dated 9/29/20 indicated R13 was cognitively intact. During an interview on 10/19/20, at 2:09 p.m. R13 stated she used to wait 10 minutes for her call light to be answered, "Today I waited 40 minutes." R13 stated, "Personally, I have not suffered any consequences of having to wait for call light to be answered...yet." R13 stated she attended resident council meetings where call light response time was discussed and management said, "We'll take care of that but we don't hear back from them." According to resident council meeting minutes, R13 attended the 7/31/20 and September 2020, meetings where call light response time concerns were raised.

A grievance report dated 7/31/20 indicated R13 reported her call lights took too long to be answered: used to be 10 minutes and now were 20 minutes. The (previous) administrator spoke to R13 and informed R13 that there would be some changes with staffing with the goal of getting more people on the floor at busy times. The administrator wrote that R13 was understanding that it was a hard time of year with full-time staff dropping to on-call or quitting to return to school, but that the facility was doing everything they could to recruit staff.

A grievance report dated 8/3/20 indicated R13 was upset due to call lights being long again on this day. R13 indicated this has been an ongoing problem and on this day was late for a visit due to waiting for someone to answer her call light. According to the grievance report, call light logs

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F 585	Continued From page 8 were reviewed for 8/3/20, and out of seven call lights for R13, one was over 20 minutes. The (previous) administrator informed R13 there would be some changes with staffing with the goal of getting more people on the floor at busy times. The administrator wrote that R13 was understanding that it was a hard time of year with full-time staff dropping to on-call or quitting to return to school, but that the facility was doing everything they could to recruit staff. NOTE: the same findings/follow up for the grievance dated 7/31/20, were added to this grievance dated 8/3/20. R7 During a telephone interview on 10/20/20, at 2:45 p.m. family member (FM)-F stated she informed SW-A that on 10/12/20, it took over a half hour for staff to respond to R7's call light to go to the bathroom. FM-F stated R7 called her at 6:30 p.m. and told her R7 pushed her call light but no one was responding. At 6:37 p.m., FM-F called the facility and no one answered the phone. At 6:40 p.m., FM-F's relative called the facility and no one answered the phone. At 6:50 p.m., FM-F called R7 back and learned staff had not arrived yet. At 6:51 p.m., FM-F called the facility again and a male answered who stated he would go to R7's room. At 6:54 p.m., FM-F called R7 again and still no staff were in her room. "I stayed on the phone with R7 until someone came to her room at 7:00 p.m." FM-F stated, "R7 had to go #2, but I think she held it." FM-F stated she felt angry and frustrated. FM-F stated, "It's appalling and heart breaking that your parent is lying there and you can't help." FM-F stated she talked to the administrator on the phone about this on 10/15/20 or 10/16/20 and stated, "It was the	F 585		

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worst conversation I've ever had with a human being." FM-F stated, "We are speaking up not just for R7, but for all the residents there, my heart breaks for them."

R7's admission Minimum Data Set (MDS) assessment dated 10/11/20 indicated R7 was cognitively intact. During an interview on 10/20/20, at 4:48 p.m. R7 stated waiting for call lights to be answered "makes me feel awful" and stated she had soiled herself a couple of weeks ago. R7 stated, "Staff don't explain why it takes so long and leadership says they will take care of it but we don't see changes."

R15's quarterly Minimum Data Set (MDS) assessment dated 8/14/20 indicated R15 was cognitively intact. During an interview on 10/20/20, at 4:27 p.m. R15 stated there had couple of times when call lights took 50 and 60 minutes to be answered. R15 stated, "I'm concerned there could be a medical emergency and no one would know it. A lot can happen in an hour." R15 stated call light response times have been brought up at resident council meetings but nothing changes. According to resident council meeting minutes, R15 attended the 7/31/20 and September 2020, meetings where call light response time concerns were raised.

During a telephone interview on 10/21/20, at 1:54 p.m. R15 told (FM)-I that it had taken 45 to 60 minutes before staff responded to her call light. FM-I stated, "Overall, it's a problem." FM-I stated, "R15 is frustrated and we are too." FM-I stated "R15 ended up messing herself with stool in the past month because she couldn't hold it." R15

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told FM-I that it takes staff such a long time to put her to bed, that she transfers herself and was not supposed to. FM-I stated, "She gets tired." FM-I was worried if R15 needed help in an emergency. FM-I stated it had not been a concern when R15 first arrived in March 2020, but it was now. FM-I had talked to SW-A about her concerns.

According to a grievance report dated 9/21/20, FM-I called the facility stating R15's call lights had been long and when would more staff would be hired. FM-I expressed concern that it was hard when R15 needed to use the bathroom and call lights were too long. According to the grievance report, DON reviewed call light reports for R15 from 9/14/20: R15 had seven call lights over 20 minutes, of those, three were over 30 minutes and of those, two were over 40 minutes. DON noted she discussed this with staff and education was provided on prioritizing call lights.

R11's quarterly Minimum Data Set (MDS) assessment dated 8/11/20 indicated R11 had moderate cognitive impairment. During an interview on 10/22/20, at 1:52 p.m. R11 who attended the September 2020, resident council meeting stated residents bring up long call light response times, "but nothing changes; nothing gets better."

During an interview on 10/22/20, at 2:05 p.m. (FM)-E stated, "R11 says she puts her light on but no one comes, so she gets up and moves herself around." FM-E stated, "R11 has had accidents (soiled herself) quite a bit, and that upsets her." FM-E stated, "To get them to find the

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time the time to help her...they are understaffed like everyone else is." FM-E stated, "I've had to call the facility to ask them to help toilet her and it just falls on deaf ears." FM-E stated, "They are overwhelmed and sympathetic, but I don't know what's happening there."

A grievance report dated 9/18/20 indicated R11 reported waiting a long time for call lights, especially on 9/18/20, so she took herself to the bathroom. It was noted that R11 expressed concern about falling due to self-transferring to the bathroom. Grievance investigation findings documented by the DON indicated a review of R11's call lights for 9/18/20, and there were 23. Of those 23, the grievance report indicated:
--six were over 20 minutes
--of those, four were over 30 minutes
--of those, three were over 50 minutes
--of those, one was one hour and eleven minutes

The grievance report further indicated the DON spoke to FM-E who stated R11 called him to say she needed to use the bathroom and no one was answering her call light, so FM-E called the facility to inform them of this. The DON spoke with another resident who went to the nurses' station for help when she noticed R11's call light on for over an hour. Actions: R11 verbalized she does not want certain staff working with her contributing to longer wait times. Grievance report indicated that when able, those staff would not be scheduled on R11's hall and R11 was in agreement with the plan.

During an interview on 10/19/20, at 10:29 a.m. nursing assistant (NA)-A stated random nursing assistants were now assigned to assist with

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baths on evening and weekends and this meant less nursing assistants on the floor to assist residents and answer call lights.

During an interview on 10/19/20, at 2:21 p.m. trained medication aid (TMA)-A stated she was not aware of a specific time frame in which call lights were to be answered and stated "I would say not longer than 20 minutes."

During an interview on 10/19/20, at 2:57 p.m. registered nurse (RN)-C stated he has been at the facility for two months did not recall anyone telling him a time frame in which call lights should be answered and added, "not longer than 15 or 20 minutes."

During an interview on 10/20/20, at 7:45 a.m. DON stated it was the facility goal to answer resident call lights before 15 minutes, adding they have been working on this with quality assurance. DON stated she realized at times it was longer than 15 minutes. DON stated, "When we get a complaint about a call light response, it is investigated." DON stated she has not looked through call light logs, but their quality person did, however she was on a leave of absence.

During an interview on 10/20/20, at 8:30 a.m. the administrator stated his expectation was for call lights be answered in 10-15 minutes. Administrator admitted he had not looked at the call light logs; the quality committee did. The administrator was not aware of policies related to call light responses times. Administrator stated he would ask residents to find out what an acceptable call light response was, but stated he had not done that.

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F 585	Continued From page 13 During an interview on 10/20/20 at 9:42 a.m. (RN)-A stated call lights were supposed to be answered in under 10 minutes by the nursing assistants. RN-A stated if a call light was not answered in 10 minutes, she radioed the NA to ask if they could answer the call light or asked if the NA needed help. During an interview on 10/20/20, at 10:49 a.m. with administrator and SW-A, when asked how call light grievances brought up at resident council meetings were addressed, the administrator stated, "I was there and addressed it," adding, "the long call light times were around meal times and had to do with Covid restrictions." Administrator stated they had put measures in place to address them, but was not able to articulate the measures. When asked if there was an action plan to address the call light response times, administrator stated, "There are all kinds of action plans I can show you." The administrator stated it was hard for the facility to move forward with the change in leadership, but "we're making progress now." The Administrator provided quality documents related to resident grievances over long call light response times. Documents provided were: 1. 7/27/20, quality assurance and performance improvement (QAPI) meeting minutes with a brief notation regarding an improvement team update on call lights, which read: overall goal to increase satisfaction from 37.5% to 50%. Secondary goal: decrease call light response times over 15 minutes will decrease from 17 out of 15. 2. 8/24/20, QAPI meeting minutes with a brief notation regarding an improvement team update	F 585		

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F 585	Continued From page 14 on call lights which read: primary goal: 37.5% to 50 % by 9/30/20. 3. 9/28/20, PowerPoint presentation titled Monthly QAPI 9/28/20, included data measures and an action plan. The action plan identified specific steps, (e.g., teach multiple ways to reduce call light response time, interview residents, reviewed call light response times at June 2020, staff meetings). There was no verification these actions to improve call light response times had occurred. The target date for all action items had expired with the exception of a new call light system, which had a target date of 10/31/20. During an interview on 10/20/20, at 11:30 a.m. with DON and SW-A, SW-A stated there were more unhappy residents and families as evidenced by an increase in grievances. SW-A stated she received voicemails and emails from families almost daily...There are so many unhappy families and complaints." SW-A verbalized examples of concerns from family members: 1) My mom was left on the toilet 2) My mom fell; what is the update? 3) I looked in mom's portal and I see she ran a temperature and no one has contacted me. 4) I went to her window and mom didn't eat her lunch. SW-A stated she tried to get a report from nursing and therapy and got back to family as soon as possible. According to the DON, there are daily meetings with human resources and stated, "We aren't getting applicants and our current staff is burned out." DON stated staffing was taking all the focus, so nothing else was getting done. DON stated, "Staff just get done what they have to do that day; nothing is being improved." DON stated, "They can't provide the care residents	F 585		

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deserve." DON verified there was no facility call light response policy to indicate expected call light response time for staff and what to do if those periods could not be met.

During an interview on 10/20/20, at 4:45 p.m. NA-B stated, "We're supposed to answer call lights in 15 minutes, 5 minutes preferably", but stated there was not enough staff to do that.

During an interview on 10/22/20, at 11:07 a.m. with corporate vice president of operations (VPO)-G and administrator, when asked about extensive grievance reports which included call light response time, change in baths schedules, medications not administered on time and food concerns (incorrect food; food not warm enough). The administrator stated there was a call light action plan to address call lights. VPO-G was not aware of all of the grievances and concerns of residents, only those that rose to a certain level. The administrator stated when he took the position in 2/2020, they had the state survey, then Covid hit, then the DON was terminated and clinical managers quit so have been trying to rebuild the organization.

During an interview on 10/23/20, at 8:18 a.m. SW-A stated grievances came from a number of sources, interviews with a resident, residents who came into her office, staff members, family members, email, phone call, voicemail messages and in person. SW-A logged the grievances into an electronic customer service database, who it was assigned to and the follow up. Stated corporate wanted them resolved in 5 days. The programs sends the grievance to the staff member assigned via email and it was up to

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F 585	Continued From page 16 them to resolve it or delegate it. SW-A monitored this and reminded the assigned person to complete it. Findings and follow up are documented and talked about at QAPI. Facility policy titled Concerns and Grievances, dated 2017, indicated: Purpose was to create an environment where resident and customer concerns are solicited and readily resolved. 1. A resident/resident representative has the right to voice grievance and concerns without discrimination or reprisal. 2. The term "voice concerns" is not limited to formal, written grievance process, but may include a resident's verbalization to staff. Concerns and grievances can be made anonymously. 3. The community views customer concerns as a primary method to learn of and meet customer expectations. In keeping with this belief, staff is trained to obtain and respond to resident/resident representative customer concerns. 4. We do not tolerate retaliation. 5. We respect resident and employee rights. 6. We encourage residents, family and employees to raise concerns at any time. 7. The community assures that after receiving a concern, there is a prompt response by the associates to acknowledge the receipt of the concern, investigate, seek a resolution and keep the resident appropriately apprised of progress toward resolution. 8. The community social services lead is the grievance officer. 9. Residents and families are informed upon admission of the concern policy/process which is posted or included in admission paperwork.	F 585		

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F 585	Continued From page 17 10. When a concern is voiced to staff, staff completes a concern form and forwards it to the social services department. 11. Social worker processes the concern. 12. The administrator and social services designee review completed concern forms. 13. A summary of concerns is reviewed at the quality council. Data is trended over time and compared to national averages to detect patterns and opportunities for improvement. If an opportunity for improvement is identified: a. related processes are reviewed and a probably cause identified b. an action plan is developed with timelines, measurable goals and person(s) responsible target. c. action plan is implemented d. follow up reports are presented at the quality council regarding effectiveness of the plan 14. Community will maintain evidence of demonstration the results of all grievance for a period of no less than 3 years from the issuance of the grievance decision. Facility policy titled Resident Council, dated 2017, indicated: Purpose was to provide for resident groups to meet and provide a forum of facility management to listen and respond to resident ideas and concerns. 1. When a resident group exists, the facility listens to resident group views, and acts up the concerns and recommendations of the residents. The facility seriously considers the group recommendations and attempts to accommodate these recommendations, so the extent practicable, in developing and changing facility policies affecting resident care and life in the	F 585		

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F 585	Continued From page 18 facility. The facility communicates its decision to the resident group. 2. Minutes are maintained for meetings and are provided, or accessible to residents. 3. The facility demonstrates follow through on written requests/concerns voiced by the resident council.	F 585		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor and assess for change of condition, and failed to follow physician orders, for 1 of 1 resident (R2) who had a history of blood clots in both legs and respiratory concerns with a potential for pulmonary emboli (PE, clots in the lungs). As a result of the facility's failures, an immediate jeopardy (IJ) situation was identified for R2 who had displayed respiratory distress with significantly low oxygen (O2) saturations, requiring an increase in oxygen and emergent transfer to the hospital emergency room (ER). The immediate jeopardy began on 9/25/20, when the facility did not send R2 to the ER per orders and was identified on 10/21/20. The administrator, director of nursing (DON), licensed	F 684	R2 is no longer in the facility. R8 is no longer in the facility. R9 is no longer in the facility. All residents on hospice, those with fluid restrictions, and all those on oxygen have the potential to be affected. "Change in Condition" policy was reviewed and remains current. "Benedictine Standing House Orders for Symptom Management", which includes bowel management protocol was reviewed and remains current. "Administering Medications" policy was reviewed and remains current. "Comprehensive Assessments and Care	12/4/20

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F 684	Continued From page 19 social worker (LSW), culinary director, and infection preventionist were notified of the immediate jeopardy at 12:45 p.m. on 10/21/20. The immediate jeopardy was removed on 10/22/20 at 5:45 p.m., but noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy. In addition, the facility failed to manage, monitor, assess for the use of bowel medications to prevent constipation for 1 of 1 residents (R8), who had a diagnosis of constipation and was on hospice for end of life care; and failed to monitor and evaluate signs and symptoms of fluid overload and follow physician orders for 1 of 2 residents (R9) with a diagnosis of stage 3 (moderate) chronic kidney disease. Findings include: R2's admission Minimum Data Set (MDS) assessment dated 9/6/2020, indicated R2 had moderate cognitive impairment and required extensive assistance from two or more staff for bed mobility and transfers and required extensive assistance from one staff for toileting, hygiene, and dressing. The MDS indicated R2 had not required oxygen, was administered anticoagulant medications, and had a surgical wound. R2's Face Sheet, included diagnoses of acute embolism, deep veing thrombosis (DVT) of right lower extremity (added 9/14/2020), and atelectasis (lung collapse) (added 9/1/2020). R2's Physician standing orders included the	F 684	Planning" policy was reviewed and remains current. "Resident Examination and Assessment" policy was reviewed and remains current. Licensed nursing staff, as part of the abatement plan, were educated on the facility's Change in Condition policy with emphasis on provider and responsible party notification and abnormal O2 sats and respiratory status. Licensed staff will be educated on the facility's Change in Condition policy, Administering Medications policy, Comprehensive Assessments and Care Planning policy and the Benedictine House Standing Orders for Symptom Management at the nursing staff trainings on 12/1 and 12/2. Licenses nursing staff, as part of the abatement plan, were educated on sign/symptoms of pulmonary emboli. Licensed nursing staff will be educated on fluid overload and bowel management with emphasis on assessment and documentation of effectiveness of PRN medications and use of electronic health record BM report at the nursing staff trainings on 12/1 and 12/. All nurses will be educated on the electronic health record Bowel and Bladder Observations (assessments) at the nursing staff trainings on 12/1 and 12/2. All nursing assistants/TMAs will be educated on the point of care documentation for bowel movements and Weight Monitoring and Documentation policy at the nursing staff trainings on 12/1 and 12/2. Audits will be completed on O2 sats and	

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F 684	Continued From page 20 following: Initiate and titrate supplemental 02 at 1-4 l/min (liters per minute) via nasal cannula PRN (as needed) for dyspnea (shortness of breath), hypoxia (02 saturation <90%); and to update provider with nursing assessment. R2's care plan dated 9/11/2020, indicated R2 experienced hypertension. Interventions were identified to include administer medications as ordered, check blood pressure per order, and observe for signs of high blood pressure including; dizziness, chest pain, dyspnea. The care plan did not address the instructions as outlined in Required Follow Up section of the hospital Discharge Summary to monitor for deep vein thrombosis (A condition in which the blood clots form in veins located deep inside the body) and PE (pulmonary embolism-A condition in which a blood vessel in the lung(s) gets blocked by a blood clot). R2's hospital Discharge Summary Brief Overview dated 9/14/2020, had a section called, Active Issues Requiring Follow-up. This section included, Continue close monitoring of the right lower extremity for propagation/worsening of swelling, evidence of neurovascular compromise (diminished pulse, numbness/tingling, new/worsening pain in the distal extremity, weakness) and any evidence of shortness of breath, chest pain, and/or hypoxemia that may suggest evidence of possibility of pulmonary embolism. Please wrap lower extremity with low stretch wraps daily for swelling control symptoms as tolerated by patient." R2's progress note dated 9/14/2020, at 10:36 p.m. included, "02 84 when lying. O2 started at 1	F 684	respiratory status 5x/week for 4 weeks. All residents are currently on covid monitoring including vitals with sats and respiratory monitoring. Audits for symptom recognition will be completed 5x/week for 4 weeks with the Electronic Medication Administration reporting function - "Facility Activity Report" which includes bowel movements, weights and fluid intake. Audits of nursing assistant documentation for bowel movements will be completed 5x/week for 4 weeks via point of care documentation. Administrator/Designee is responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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lit [liter] per minute. Call light within reach. Will continue to monitor." The note also indicated a skin assessment was completed; purple blueish coloration of right lower leg, edema +1. Scar from surgery 5 centimeters long.

R2's physician visit dated 9/15/2020, included recapitulation of hospital admission and discharge orders for active surveillance of the right lower extremity, monitoring for signs/symptoms of pulmonary embolism, worsening DVT, and oxygen requirements. The note indicated nursing reported increased oxygen need when working with physical therapy, and physical therapy requested order to increase oxygen for therapy sessions. Resident denied shortness of breath, chest pain, numbness and tingling in the extremity. The note indicate the physician would consult with vascular clinic for increasing oxygen. Physical exam, skin: Purple bluish coloration of right lower leg. Edema +1 right leg. The note included orders for ultra sounds and "3. Nursing will continue close monitoring of right lower extremity for swelling, diminished/loss of pulse, numbness/tingling, new/worsening pain in the distal extremity, weakness, shortness of breath, chest pain, and/or hypoxemia that may suggest possibility of pulmonary embolism."

R2's progress note dated 9/15/2020, at 4:21 p.m. indicated a telephone order was obtained from the NP (nurse practitioner); oxygen needs to be increased to 3 lpm to keep Sp02 above 90%. "Resident noted to de-sat with exertion." A subsequent note at 9:49 p.m. included the ultra sound results; "No DVT is seen in bilateral lower extremities."

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F 684	Continued From page 22 R2's progress note dated 9/16/2020, at 2:01 p.m. "PT [physical therapist] found pt [patient] sleeping in w/c [wheelchair] and didn't touch her lunch, refusing it. Pt on room air and O2 SATS 95%. sit to stand CGA [contact guard assist] .... Pt stood for 1 min [minute] w/ PT limiting time to assess O2 and initially 92% upon sitting and then decreased to 73% and took about 1 min to rebound. PT donned O2 at 1 lpm and O2 93%. Stood 2nd time and able to place oximeter on finger and decreased to 66% after about 45 sec [seconds] of standing and had pt immediately sit down. Vital machine then had dead battery and cord retrieved to plug in and by the time this took place O2 at 78% and then quickly returned to >90%. O2 increased to 3 lpm and pt stood 3rd time and watched O2 and decreased to 78% at 20 sec and had pt stop. Pt took 1 min 20 sec to recover. Reassessed O2 SATS to do quick wean back to room air and at [sic] was in 80's and quickly above >90. Monitored to 2 lpm, 1 lpm and to room air w/ pt at 100% by end. Notified nurse of pt desaturation w/ activity as nurse arrived to give meds." R2's progress note dated 9/17/2020, at 11:39 a.m.stood with PT for 1 minute, and PT would not let patient stand longer to ass O2 sats/tolerance. Donned oximeter after standing and O2>90% entire stand. After sitting, O2 eventually dropped to 81% after sitting for awhile and with therapeutic rest at 100%. Pt stood 2nd time and 15 seconds only as O2 dripped to 85% quickly and made pt sit down with O2 dropping to 74% with about 1 mine to recover. Discontinued standing attempts at this time.	F 684		

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F 684	Continued From page 23 R2's progress note dated 9/18/2020, at 11:13 a.m. indicated R2 denied feeling any shortness of breath and did not display symptoms when laying down. A subsequent note at 1:13 p.m. included, "PT just completed the following concerning tx [treatment]: Pt found asleep in w/c w/ lunch tray, on room air. O2 SATS 84% on R [right] hand and compared to L [left] hand at 80%. PT donned O2 on 3 lpm to increase O2 SATSs for mobility and increased to 95%. Pt stood CGA w/ FWW [front wheeled walker] and decreased to 69% after just 25 sec of standing and had pt sit back down. Pt took 2 1/2 min to recover >90%. PT was not going to stand pt again, however, pt requesting to use toilet urgently and instructed pt on need to transfer quickly to keep O2 SATS up. PT had pt rest prior to toilet transfer CGA and O2 decreased to 49% on 3 lpm. PT immediately notified nsg [nursing]. Nurse arrived while pt on toilet and updated and nurse stayed present for toilet>w/c transfer w/ CGA and dependent upon changing and cleaning. O2 SATS then decreased to 39% with O2 on 3 lpm and took 5 1/2 min to recover >90%. Nurse to update NP and rest of tx withheld. At rest in w/c observed O2 SATS in mid 60's to 100% while PT documenting" R2's clinic registered nurse telephone encounter note dated 9/18/2020, at 1:23 p.m. included, "Call received from nurse [name of nurse] at Madonna Towers, Resident was in PT [physical therapy] when resident's 02 saturation was checked. Room air sats were 95%. Nurse states that resident's 02 sats were going as low as 50% with oxygen 3L on, even at rest. Resident appears in no apparent distress. No shortness of breath or cyanosis (bluish discoloration) noted. Writer asked for accuracy of unit used to test. She	F 684		

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states they compared with another machine and were getting the same kind of readings. She states readings were "all over the place" at standing and sitting positions. Writer requested an S-bar be sent with updated vitals. Resident remains on 3L of 02.

R2's follow-up physician's note dated 9/18/2020, at 1:43 p.m. included "Called facility and talked to [name of nurse]. 02 sat reading was all over the place, at 3L was as low as 50% and they're certain of the accuracy of the equipment. Resident was just admitted to [name of hospital] and treated for DVT. With concern for pulmonary embolism, I gave order to send her back to [hospital name] ED".

R2's physician note dated 9/18/2020, at 2:25 p.m. included "NP called [nurse name], who reported that the ambulance came, EMT assessed her and found her 02 sat was normal. They stated that she's stable and did not take her to the ED. Nursing was instructed to keep a close eye on her over the weekend. 1. Take VS [vital signs 3 times daily for 3 days. Notify [provider] on call if 02 drops <90% on 1 LNC (baseline since hospitalization) or if RR [respiratory rate] >24. 2. Assess for SOB [shortness of breath], chest pain, cough, dizziness/lightheadedness, increased leg pain or swelling when taking vital signs."

R2's progress note dated 9/18/2020, at 3:00 p.m. indicated the physician was notified, physician recommended sending R1 to the emergency room for further evaluation. Emergency medical services was called and upon arrival; "EMS evaluated her and decided she did not require hospitalization at this time." Physician called back

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and agreed to have nursing staff "monitor her closely over the weekend. If any changes occur, we are to send her in."

R2's progress note dated 9/22/2020, indicated R2 was seen by the doctor, had an ultra sound that resulted in "Bilateral non-occlusive deep venous thrombosis is seen."

R2's record lacked documentation of further monitoring of the right lower extremity.

R2's physician visit note dated 9/22/2020, indicated R2 was seen for initial physician visit. The note included a section Physical Exam; the section only included "Constitutional: She appears well-developed. Psychiatric: She has normal mood and affect." The physician ordered labs on next lab day and for nursing to continue close monitoring of the right lower extremity.

R2's progress note dated 9/25/2020, at 9:22 a.m. included "Res [resident] was not responding to command. This AM. oxygen was 67 at 4 L. Her body was very cold to touch. She was covered with extra blanket and was monitored for an hour, oxygen was 56 even with nasal cannula. Ambulance was called and she was transferred to the hospital." The note lacked documentation the physician had been notified of R2's oxygen saturation less than 90% and acute change in condition.

R2's progress note dated 9/28/2020, indicated family contacted the facility and reported R2 was close to death.

During an interview on 10/20/2020, at 6:22 p.m.

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family member (FM)-A stated on 9/23/2020, she had been at work and received a call from a nurse at the facility before 4:00 p.m.; the nurse indicated R2 may be going into the emergency room for non-emergent cares. FM-A stated she arrived at the facility around 5:20 p.m. and around 6:00 p.m. the nurse told her that instead of sending R2 to the ER, R2's vascular doctor had ordered an increase in lovenox. FM-A stated that on 9/25/2020, once at the hospital a tube was put up R2's nose to pump her stomach that resulted in not a huge amount of fluid but a good amount, R2 also had blood in her stools. FM-A stated R2's death certificate included, "Complications of right hip fracture-fall, hypertension, and Alzheimer's disease.

On 10/21/2020, at 8:00 a.m. director of nursing (DON) reviewed R2's oxygen saturation records and stated "the monitoring and assessing of respiratory status was lacking, there was inconsistent documentation of how much oxygen she was being used therefore would not be able to ascertain worsening respiratory condition." DON stated on 9/25/2020, upon discovery of R2's 02 saturations, 911 should have been called as well as the physician instead of monitoring R2 for an hour. The DON also stated staff should have notified the family member on 9/18/2020, when they were going to send her in to allow participation in the care plan. DON then stated "progress notes and record are not complete and leave a lot of unanswered questions. There was a lack of monitoring of the lower extremity for changes in color/warmth/sensation or color."

During an interview on 10/21/2020, at 3:03 p.m. registered nurse (RN)-C indicated if resident had

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F 684	Continued From page 27 low oxygen saturations, would check standing orders, place on oxygen and call 911 and/or physician dependent upon situation. During an interview on 10/23/2020, at 5:03 p.m. RN-B stated he was the nurse that found R2 with low oxygen saturations. RN-B stated it was an error in judgement at the time and should have called the physician and ambulance immediately. The Immediate Jeopardy was removed on 10/22/2020, at 5:45 p.m. when it was determined the facility provided re-education and competency testing to licensed nursing staff on the facility's change of condition policy with emphasis on abnormal respiratory status and signs/symptoms of pulmonary embolism. In addition, the facility developed and implemented an auditing system for respiratory monitoring. R8 CONSTIPATION: R8's significant change Minimum Data Set (MDS) assessment dated 7/23/2020, indicated R8 had been admitted to hospice, did not have cognitive impairment, and did not have rejection of care behaviors. According to the MDS, R8 required extensive assistance from two or more staff members for bed mobility, dressing, and toilet use. The MDS indicated R8 was always incontinent of bowel. R8's Face Sheet, included diagnosis of irritable bowel syndrome, constipation, and heart burn. R8's care plan dated 7/17/2020, included "Resident has a terminal diagnosis and is receiving hospice services through [name of hospice agency], with the goal of "will be kept as	F 684		

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comfortable as able with through collaboration with hospice for end of life care." Interventions included, Administer medications as ordered, monitor and document effectiveness of medication. Follow-up with hospice/provider as needed. The elimination care plan edited on 7/28/2020, indicated R8 had alteration in elimination related to decreased mobility and opioid medication with the goal of "will have no s/sx [signs/symptoms] of constipation through the review date" (goal dated 6/29/2020). The interventions included, administer medications as ordered and observe for effectiveness, see comfort/pain opioid care plan (7/28/2020), If no bowel movement in three days follow bowel protocol per standing orders (6/29/2020), Observe for s/sx of constipation: passing hard/no stools, abdominal bloating/swelling, cramping, nausea and/or vomiting, mental status changes (6/29/2020) assist of one stand pivot wheelchair to/from toilet.

R8's physician orders included the following:
-Morphine concentrate solution 5 milligrams (mg) as needed (PRN) by mouth every hour as needed for shortness of breath or pain (start date 7/18/2020, end date 8/9/2020)
-Lactulose (laxative) 15 milliliters (ml) once a day PRN for constipation (start date 7/15/2020, end date 8/5/2020)
-Lactulose 15 ml by mouth daily and may also take 15 ml daily as needed for constipation (Start date 7/15/2020, end date 8/5/2020)
-Lactulose 30 ml twice daily (start date 8/5/2020, end date 8/11/2020)
-Senna with Docusate Sodium 8.6/50 mg, take two tablets in the morning and 3 tablets at bedtime (start date 7/15/2020, end date

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F 684	Continued From page 29 7/28/2020), order was changed on 7/28/2020 - take 3 tabs twice a day with a stop date 8/11/2020. -Bisacodyl 10 mg suppository once a day PRN (start date 7/19/2020, end date 8/10/2020. -Bisacodyl tablet 5-10 mg once daily PRN (start date 7/15/2020, end date 8/5/2020) -Bisacodyl tablet 5 mg by mouth once day (start date 8/5/2020, stop date 8/11/2020) -Fleet enema 19-7 gram/118 ml; 1 tube, one time dose per standing order (7/26/2020) -Fleet enema one tube, every three days PRN for constipation if no results from suppository (start date 8/2/2020, end date 8/11/2020) Miralax 17 grams once a day (start date 8/5/2020, end date 8/11/2020. Facility standing orders signed by medical director on 3/1/2019, for Bowel and Bladder Management included the following for constipation; (Perform step sequentially) Perform rectal check to determine if impaction is present, Bisacodyl suppository 10 mg per rectum twice a day for constipation. Reattempt Senna or Bisacodyl if no results after 24 hours. Fleets enema per rectum every 3 days PRN for constipation if no results from suppository. R8's Medication Administration Records (MAR), in combination with Bowel Movement Record (BMR), and progress notes were reviewed. The record consistently lacked a comprehensive bowel assessments; the record did not identify physical examination such as abdominal distention, presence of bowel sounds, or firm/soft abdomen. The record identified bowel medications were not given per physician order and no follow up of effectiveness when the bowel	F 684		

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F 684	Continued From page 30 medication was given. R8's progress note dated 7/22/2020, indicated R8 reported constipation "relieved with suppository and laxatives" had large bowel movement. R8's BMR identified R8 did not have bowel movements on 7/23, 7/24, and 7/25/2020. One PRN dose of Lactulose was administered on 7/25/2020; dose was documented as not effective, no further interventions documented. MAR indicated no PRN suppositories were administered. R8's MAR on 7/26/2020, indicated R8 was administered a Fleets enema, one time with special instructions: Day 4 no BM per standing order, with medium results. The BMR at 1:22 p.m. indicated R8 had a large bowel movement and at 7:22 p.m. had a medium bowel movement; consistency of BM was not identified on the BMR. R8's BMR included the following recordings: - 7/27/2020, medium bowel movement (no consistency identified). -7/28/2020, no bowel movement -7/29/2020, no bowel movement -7/30/2020, no bowel movement, MAR indicated PRN dose of Lactulose administered was not effective; no other intervention. -7/31/2020, no bowel movement, MAR indicated Bisacodyl suppository administered day 4 no BM and was not effective. -8/1/2020, no bowel movement - 8/2/2020, R8 had medium bowel movement that was dry and hard. MAR indicated R8 was	F 684		

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administered PRN lactulose that was not effective.
-8/3/2020, no bowel movement. PRN Bisacodyl suppository and lactulose administered and was not effective.
-8/4/2020, medium bowel movement that was soft/formed. MAR indicated lactulose and Bisacodyl administered and were not effective.
- 8/6/2020, no bowel movement; MAR identified Miralax was administered per schedule, no PRN bowel medications administered.
-8/7/2020, no bowel movement; MAR identified scheduled medications given, Bisacodyl administered and charted as effective although there was no bowel movement recorded. R8 was administered morphine 5 mg at 4:52 p.m. for bottom pain 5/10; record lacked evaluation of effectiveness.
-8/8/2020, small bowel movement that was dry and hard; MAR identified Bisacodyl administered for day 4 without a bowel movement; documented as effective. R8 refused Senna S, record lacked evidence after refusal R8 was re-approached. R8 was administered Morphine 5 mg at 2:58 p.m. for discomfort when trying to have bowel movement and shortness of breath, and at 4:58 p.m. for bottom pain.
- 8/9/2020, 2 small bowel movements (consistency was not identified); MAR indicated R8 refused suppository, Miralax, and Senna S.
- 8/10/2020, indicated R10 had small soft/formed stool, large loose stool, and another large bowel movement.

R8's progress note dated 8/2/2020, included "Resident complaining of discomfort in abdomen. Has no bowel movement for 6 days. On scheduled and as needed morphine sulfate. Oral

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laxatives and Bisacodyl suppository ineffective. Fleets enema given as per standing order. Effective with medium hard stool. Resident verbalized relief with abdominal discomfort." The note also indicated oral laxative encouraged.

R8's progress note dated 8/3/2020, hospice called to update on not eating and need for bowel medication due to constipation.

R8's hospice visit note dated 8/3/2020, included "patient received suppository and nurse assist to digitally remove hard stool. Patient reports she is no longer constipated and staff confirm she had a small BM today. Bowel sounds active in to all four quadrants, abdomen soft and not tender. Writer discussed bowel regimen with facility nurse, who reports they will continue to monitor and utilize PRNs as the pt refuses to schedule more laxatives at this time despite writer's education and recommendations." The note also indicated the nurse reported the facility had been giving PRN Bisacodyl suppositories.

R8's hospice note dated 8/4/2020, at 9:45 a.m. indicated family member called hospice, "stating that pt is in significant pain due to constipation, and pt is requesting to go to the hospital." The note indicated hospice called the facility and instructed the nurse to give prn dose of lactulose. Nurse reported that lactulose and suppository would be administered later that afternoon. At 12:15 p.m. the family had communicated back to hospice that a suppository and enema were used with no results, the hospice nurse called hospice physician and obtained new orders. The note indicated the facility would call hospice when R8 had results after medications were given as

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F 684	Continued From page 33 directed by hospice nurse. R8's progress note dated 8/4/2020, at 1:09 p.m. indicated R8 reported constipation, scheduled bowel medication suppository and enema given per hospice order with small smeared results. "PRN morphine given for comfort during care, transferring, and discomfort due to constipation." The note indicated hospice was updated during visit and via phone related to bowel management. A subsequent note at 1:46 p.m. included, "STAT verbal order for another lactulose PRN per hospice for constipation placed." Note at 9:54 p.m. included, "Resident had a medium bowel movement this evening." Results were communicated to hospice nurse. R8's progress note dated 8/5/2020, indicated hospice at the facility and gave new orders; Bisacodyl 10 mg daily and increase lactulose to 30 ml twice a day. A subsequent note at 7:50 p.m. indicated staff had reported R8 had large bowel movement during evening cares. According to R8's MAR on 8/5/2020, R8 was administered Morphine 5 mg at 3:23 p.m. for rectal pain, record did not identify the effectiveness of the medication. R8's progress note dated 8/8/2020, indicated took her bowel and pain medications. A subsequent note at 8:47 p.m. indicated cream was applied to residents bottom due to discomfort after bowel movement. R8's progress notes dated 8/9/2020, at 8:25 a.m. indicated hospice was updated related to pain management due to discomfort with direction	F 684		

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from hospice to stay on PRN medications as ordered. The note indicated R8 was administered the pain medications and had good results. A subsequent note at 4:04 pm. indicated R8 had refused her morning medications. Family member was present, asked medications be administered including lactulose and senna. "Resident started to have peristalsis (the involuntary constriction and relaxation of the muscles of the intestine or another canal, creating wavelike movements that push the contents of the canal forward) which caused abdominal discomfort and pain. PRN morphine given hourly per order with less effect on pain management." The note then indicated hospice was contacted and increased morphine.

R8's record lacked staffs re-attempt of administration of bowel medications after it was initially refused.

R8's progress note dated 8/10/2020, at 5:51 a.m. indicated R8 had a soft small bowel movement when she was repositioned.

R8's progress note dated 8/10/2020, at 1:28 p.m. (late entry documented on 8/11/2020 at 1:40 p.m.) included, "Resident restless and c/o [complained of] pain." Note indicated R8 was administered pain medication and Haldol for anxiety. "This writer brought Bisacodyl suppository to her room to administer d/t resident refusing oral bowel medications and only having small bm's. Resident refusing stating "NO, NO, NO suppository." Residents daughter was in the room at the time and agreed with residents request. Hospice here around lunch time and resident still having increased anxiety and

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restlessness" the note indicated the nurse tried to offer the suppository again and the resident refused.

R8's hospice visit note dated 8/11/2020, included "RN did rectal check due to complaints of having rectal pain. [Name of nurse] LPN [licensed practical nurse] did not give suppository as requested by this RN on 8/11/2020 due to pt refusal. RN noted pt to have hard stool in rectum and disimpacted XL [extra large] hard stool. RN was unable to complete disimpactaction due to pt have bleeding from rectum in moderate amounts (possible hemorrhoid). RN applied pressure to rectal area to slow down the bleeding. RN gave pt Dulcolax suppository to promote further BM. Bowel sounds hypoactive x 4. After pt was disimpacted, she was able to relax with no facial grimacing or restlessness noted in bed." The note also indicated the resident was transferred to hospice house.

During an interview on 10/21/2020, at 8:51 a.m. nursing assistant (NA)-D stated NA's were supposed to record bowel movements, sometimes things didn't get charted, and didn't think there was a way to look back at the history. NA-D stated the nurses were supposed to make sure residents had bowel movements and administer suppositories if they didn't have one every three days.

During an interview on 10/21/2020, at 9:23 a.m. NA-C stated NA's were supposed to document bowel movements however, needed work. NA-C indicated agency staff were not documenting. NA-C indicated a suppository was supposed to be given if a resident did not have a bowel

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movement every three days; that it was up to the nurse to administer the suppository.

During an interview on 10/21/2020, at 9:34 a.m. licensed practical nurse (LPN)-A stated NA's were supposed to document bowel movements and report to the nurse if haven't had a bowel movement in 3 days or if resident complained of constipation. LPN-A stated TMA's have to check with nurses prior to holding any medications for an assessment to be completed. LPN-A stated physician's orders should be followed for bowel medications. If a bowel medication was not effective, then more follow-up was required.

During an interview on 10/21/2020, at 12:16 p.m. registered nurse (RN)-A stated there was a bowel movement report sheet. RN indicated the report was supposed to be pulled up during the shift; if no bowel movements in 3 days then a suppository was supposed to be given. RN indicated if it was not effective then more follow-up was supposed to be completed. RN stated a complete bowel assessment should be completed prior to the administration of bowel medications and/or when a resident would complain of constipation.

During an interview on 10/21/2020, at 3:03 p.m. registered nurse (RN)-C stated a complete bowel assessment should be completed and documented prior to the administration of laxatives. RN-C indicated if no bowel movement in three days supposed to get a suppository, and if there was not results then more intervention needed to be completed. RN-C stated documentation is not always accurate, and does not always identify consistency; stated there isn't

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a standard for size documentation and indicated it was left up to the person recording to determine difference between small/medium/large.

During an interview on 10/23/2020, at 7:42 a.m. director of nursing (DON) reviewed R8's record; and confirmed physician orders for bowel management were not followed. DON stated nursing should have followed the bowel regimen per physician orders. DON stated they should be documenting refusals and need to re-attempt to administer, if a TMA documented refusals they should have reported to a nurse and document what happened. DON stated bowel assessments should be completed when complaints of constipation and/or before administering a PRN medication.

During a return phone interview on 10/29/2020, at 3:30 p.m. with nurse practitioner (NP)-B, NP-B stated staff should be administering bowel medications per orders. NP-B indicated fleets enema should not be given before using the prescribed medications. NP-B stated an expectation that nurses complete full bowel assessments daily if there was constipation concerns and before administration of as needed medications.

R9 FLUID OVERLOAD

R9's admission Minimum Data Set (MDS) assessment dated 9/28/2020, indicated R9 did not have cognitive impairment and required extensive assistant of two or more staff for bed mobility, dressing and personal hygiene. The

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F 684	Continued From page 38 MDS also indicated R9 received one administration of a diuretic during the assessment period. R9's Face Sheet, included diagnoses of essential hypertension, venous insufficiency, cirrhosis of the liver (scarring of the liver), chronic kidney disease stage 3(moderate kidney damage), rheumatic tricuspid insufficiency (failure of the heart's tricuspid valve to close properly), and secondary pulmonary hypertension. R9's nutrition care plan dated 9/23/2020, identified R9 was on a fluid restriction; interventions included document meal intake %, fluids, bowel movements, and urinary output as applicable each shift. Notify licensed nurse for low intake and refused meals. R9's Hospital Discharge Summary Brief Overview dated 9/21/2020, indicated R9 was hospitalized related to anemia iron deficiency blood loss. The section Active Issues Requiring Follow-Up included primary care provider to consider starting Torsemide (diuretic) at dose of 10 milligrams (mg) based on creatinine (lab) levels. R9's physician orders included: -Check heart rate, blood pressure, and Sp02 (oxygen saturations) daily (include oxygen requirement) Special instructions: Notify [name of clinic staff] if SBP (systolic blood pressure] >160 or SBP <90, HR (heart rate) >100 or <60, Sp02 <90% or increased oxygen needs, or with any other concerns (start date 9/24/2020, stop date 10/2/2020) - Check heart rate, blood pressure, and Sp02	F 684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 39 daily (include oxygen requirement) Special instructions: Notify [name of hospital staff] if SBP (systolic blood pressure] >160 or SBP <90, HR (heart rate) >100 or <60, Sp02 <90% or increased oxygen needs, or with any other concerns. For heart rate <60 only notify provider if symptomatic (dizziness/lightheadedness or syncope (start date 10/2/2020, stop date 10/5/2020) -No added salt diet. Special instructions <1.5 fluid restriction (start date 9/21/2020) -Weight daily before breakfast. Use the same scale. Notify provider if weight gain >267 lbs. (pounds) or <261 lbs. (start date 9/28/2020. -Torsemide 10 milligrams (mg) now and then daily in the morning (start date 9/28/2020) -Apply low stretch wraps to bilateral lower extremities, on in the a.m. and off in the p.m. (start date 9/28/2020) R9's vital sign record was reviewed; the record identified heart rates under 60 without evidence the physician had been notified. 9/21/2020, 11:49 a.m. HR 56 9/22/2020, 2:59 p.m. HR 55 9/22/2020, 9:32 a.m. HR 58 9/22/2020, 6:51 p.m. HR 55 9/23/2020, 7:28 p.m. HR 57 9/24/2020, 10:26 p.m. HR 58 9/25/2020, 7:34 a.m. HR 56 9/26/2020, 12:25 p.m. HR 55 9/27/2020, 9:48 a.m. HR 55 R9's 24 hour fluid intake from 9/21/20 to 10/5/20, lacked documentation the facility had implemented R9's fluid restrictions on 9/23/20, 9/25/20, 9/30/20, 10/3/20 and 10/4/20.	F 684		

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F 684	Continued From page 40 R9's daily weight record from 9/22/20 to 10/6/20 revealed R9 had not been weighed 10 of the 15 days: -9/22/2020, wt. (weight) 264.7 lbs. -9/23/2020, wt. not taken -9/24/2020, wt. 256.3 lbs. -weight not taken on 9/25, 9/26, 9/27, 9/28, or 9/29/20. -9/30/2020, wt. 274.2 lbs. -10/1/2020, wt. not taken -10/2/2020, wt. not taken -10/3/2020, 276 lbs. -10/4/2020, 276 lbs. -10/5/2020, wt. not taken -10/6/2020, wt. not taken R9's record lacked evidence of consistent monitoring and evaluation of R9's weights and edema (swelling caused due to excess fluid accumulation in the body tissues) and lacked evidence R9's physician had been notified of the increased weight to 276 until 10/6/20. R9's progress notes from 9/21/20 to 10/6/20 revealed the following: - 9/21/2020, included resident has grade I (pressure applied to area leaves an indentation of 0-2 millimeters (mm) that rebounds immediately) pitting edema in bilateral lower extremities, with wraps on from the hospital and encouraged to elevate legs when at rest. -9/22/2020, included no edema observed at this time. - 9/28/2020, indicated R9 had a telehealth appointment for evaluation of hypertension. The	F 684		

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note indicated the physician ordered Torsemide daily in morning and apply low stretch wraps to bilateral lower extremities, on in the morning off at night, ordered labs for 10/1/2020, and weigh patient daily in fasting state every morning using the same scale.

-10/1/2020, at 1:09 p.m. indicated R9 had low diastolic pressure and heart rate less than 60 and symptomatic. SBAR (a communication tool) done. A subsequent note at 2:29 p.m. indicated R9 had 3+ pitting edema in both legs.

-10/2/2020, at 2:29 p.m. indicated R9 had 3+ pitting edema in both legs.

-10/3/2020, indicated R9 was having increased confusion, urinary frequency and yelling out, SBAR was completed and faxed for request for urine test.

-10/4/2020, indicated R9 continued to yell out and had increased confusion, physician was called, physician directed to closely monitor and report any increased signs of confusion, decreased intake, fever, and did not want a urine test done right now.

-10/5/2020, indicated R9 was calm and slept all night and would follow up with SBAR today.

-10/6/2020, included "resident had a meeting with her provider this morning. Likely in fluid overload and needing diuresis. Provider gave order to send resident to emergency department.

R9's progress notes lacked documentation of monitoring of fluid status, edema or daily weights

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F 684	Continued From page 42 consistently per physician orders. R9's physician notes from 9/28/20 to 10/6/20 revealed the following: -9/28/2020, R9 had a telehealth visit for evaluation of hypertension. The note included "the patient has an order for daily weights with a target range of 261-267 lb. unfortunately she has not been weighed since 9/24/2020 and her weight at that time was 256.3 lb." The note also indicated her blood pressures had been running low, usually 90's systolic over 50's to 60's diastolic. The visit indicated the Torsemide was started related to hyponatremia (low sodium), labs were ordered, plan to follow-up later that week. -10/1/2020, at 9:00 a.m. "Patient does have weight parameters to notify provider if weight is less than 261 lb or greater than 267 lb. SNF [skilled nursing facility] documentation of weight has been very inconsistent. The weights that have been recorded are quite variable. She had not been weighed at the time of my video visit today and up to this point, there is nothing documented in EMR [electronic medical record]. I have made 3 separate attempts to contact SNF for today's weight. I have been unable to get a nurse at Madonna Towers." The note also included, "Patient does report bilateral lower extremity edema, worse in the right than the left. Her legs are currently wrapped." The visit note indicated the plan was to continue Torsemide for hyponatremia, ordered labs for 10/6/2020, and follow up next week. -10/5/2020, "Attempted to see the patient today.	F 684		

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Initially she was working with therapy and on her way to the bathroom. Nursing agreed to meet me again at 11:15 a.m. to see patient. Nursing did not log on at 11:15. Received page later stating nursing was ready for me to see patient, however, nursing was not signed on. Attempted to call Madonna Towers, but could not reach a nurse. Of note patient is scheduled for follow-up tomorrow, can address UTI symptoms at that time, if nursing signs onto virtual visit. "

-10/6/2020 "I had attempted to see the patient yesterday for [name of person] concern of UTI symptoms. Nursing was unavailable to assist with virtual video." Therefor the patient was seen today. At time of visit she appeared lethargic and unable to answer questions other than to voice her need to urinate." The note also included, "Per nursing staff [name of nurse] patient is unwell and weak today, [name] states that patient has been confused for two days and has been experiencing urinary frequency. [Name] also states that her eyelids appear to be swollen." The note indicated R9 was alert to person and year and did not know where she was located. The note indicated the physician gave an order to transfer to emergency room for decline in condition.

During an interview on 10/21/2020, at 9:23 a.m. NA-C stated NA's tried to get daily weights however, it didn't always happen because staff were busy in the morning. Stated if we miss a weight then the bath aide would attempt to get the weight on the resident.

During an interview on 10/21/2020, at 9:34 a.m. licensed practical nurse (LPN)-A stated edema

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should be monitored daily with weight. LPN-A stated she did not think it was being documented, and it would be important to identify a change in condition.

During an interview on 10/23/2020, at 7:42 a.m. director of nursing (DON) reviewed R9's record and confirmed weights were not obtained per order, lack of edema monitoring and evaluation, and the physician was not notified when heart rate was below 60 per the order. DON stated the documentation did identify if R9's was assessed for symptoms for lower heart rate.

During a return phone interview on 10/29/2020, at 3:30 p.m. with nurse practitioner (NP)-B, NP-B stated completing daily weights at the facility has been an ongoing problem. NP-B stated residents were given set parameters on when to notify the physician and they were also given specific directions on obtaining daily weights in the morning, before breakfast, using the same scale. NP-B indicated that in order for the resident to get the appropriate treatments nursing had to be monitoring and assessing for changes in weight, fluid balance, and swelling.

A facility policy/protocol for fluid management was requested and not received.

Facility policy Change in Condition dated 2/2019, included "When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative. The policy did

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F 684	Continued From page 45 not specifically define what constitutes a change in condition. A facility policy/protocol for bowel management was requested and not received. Facility policy Administering Medications 2/2019, included; To administer resident medications in a safe and accurate manner that will ensure the 6 rights of medication administration. Medications are administered in accordance with the orders. 3. Medications are administered within their prescribed time. Any refused medication is destroyed and documented as a refusal (did not instruct to re-attempt). Facility policy Change in Condition dated 2/2019, included "When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative. The policy did not specifically define what constitutes a change in condition.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of	F 688		12/4/20

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F 688	Continued From page 46 motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff provided restorative services to meet the assessed needs for 3 of 3 residents (R11, R12, R13) reviewed for restorative services. Findings include: R13 R13's face sheet printed on 10/23/30, indicated diagnoses of ataxia (impaired balance or coordination) and degeneration of nervous system (loss of function or structure of nerves of the spinal cord). R13's quarterly Minimum Data Set (MDS) assessment dated 9/29/20, indicated R13 was cognitively intact, had adequate hearing and vision, clear speech, was understood and had clear comprehension. R13 required extensive assistance of one staff for bed mobility, transfers, toileting, and locomotion on and off the unit. Walking in her room or corridor occurred only once or twice. R13's care plan category called restorative	F 688	R11's care plan was reviewed and revised. R12's care plan was reviewed and revised. R13's care plan was reviewed and revised. All residents with restorative plans have the potential to be affected. All restorative plans were reviewed and care plans revised as necessary. "BHS Restorative Program" policy was reviewed and remains current. All nursing assistants will be educated on the documentation of restorative plans at the nursing staff trainings on 12/1 and 12/2. Audits of completion of restorative plans and accompanying documentation will be completed 3x/week for 4 weeks. Administrator/Designee is responsible for compliance. Results of monitoring shall be reported at	

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F 688	Continued From page 47 nursing dated 3/25/20, indicated R13 required restorative program to address neuromyopathy (disease of nerves) and degenerative disease of the nervous system with decreased mobility. Goals and approaches indicated R13 would continue to ambulate 150 feet daily and use the NuStep (stationary bicycle) 10 minutes daily between 6:00 a.m. and 2:15 p.m. R13's point of care history report indicated the frequency of restorative nursing related to walking. The report indicated R13 ambulated zero times between 9/21/20 and 10/22/20. Three times, the report listed the reason as "refused." Other reasons included: not observed, could not assess, deferred due to condition, unavailable and unknown. During an interview on 10/22/20, at 12:45 p.m. R13 stated when they had a restorative aid, she was able to use the NuStep and walk in the hall, but now that they were short staffed, this was not happening. R13 stated only two staff have asked her if she wanted to walk in the past six weeks. R13 admitted she sometimes refused to walk due to the small stature of some staff, as she doesn't feel safe with them. R13 stated she was not confident in the ability of staff providing restorative services. R13 stated, "I'm paying a lot of money to be here and they aren't always meeting my needs." R13 stated this has been brought up at resident council, "but the new management is more concerned about the bottom line then the residents." R13 stated she was not able to tell if the lack of restorative services had affected her, but expressed concern that it may eventually "catch up."	F 688	the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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F 688	Continued From page 48 R12 R12's facesheet printed 10/23/20, indicated diagnoses of Parkinson's disease (disease affecting movement), age-related physical debility, osteoporosis (bones become weak and brittle), muscle weakness and repeated falls. R12's quarterly Minimum Data Set (MDS) assessment dated 8/18/20, indicated R12 was cognitively intact, had adequate hearing, impaired vision requiring corrective lenses, clear speech, was understood and had clear comprehension. R12 required extensive assistance of two staff for bed mobility, transfers and toileting, and required extensive assistance of one for dressing, walking in her room and locomotion on the unit. R12's care plan category called restorative nursing dated 3/24/20, indicated R12 required restorative program to address Parkinson's disease with muscle weakness. Goals and approaches indicated R12 would maintain the ability to ambulate 200 feet daily and ride NuStep for 10 minutes daily, between 6:00 a.m. and 2:15 p.m. R12's point of care history report indicated the frequency of restorative nursing related to walking. The report indicated R12 walked 200 feet daily during the specified time frame only seven times between 9/21/20 and 10/22/20, and only one time did she walk 200 feet. Twice the report listed the reason as "refused." Other reasons included: not observed, could not assess, deferred due to condition, unavailable and unknown.	F 688		

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During an interview on 10/22/20, at 1:31 p.m. R12 stated, "If they walk me once a week, I'm doing good, and I do need it. I'm getting weaker every day and I'm not going to last long at this rate. I'm not active enough." R12 stated she was not using the NuStep at all anymore, adding "they didn't renew that gal's contract so there is no one to sit with you while you do it." R12 stated she would like to walk in the hallway. R12 stated that in the morning, she would ask staff if she could walk and staff say, "later, but later never comes."

R11
R11's facesheet printed 10/23/20, indicated diagnosis of dementia, age related physical debility, osteoarthritis (wearing down of bones) and muscle weakness.

R11's quarterly Minimum Data Set (MDS) assessment dated 8/11/20 indicated R11 had moderate cognitive impairment, had adequate hearing and vision, clear speech, was understood and had clear comprehension. R11 required extensive assistance of one staff for bed mobility, transfers, toileting and locomotion on and off the unit. R11 required limited assistance of one when walking in her room, and walked in the corridor with assistance of staff only once or twice.

During an interview on 10/22/20, at 1:52 p.m., R11 stated she wanted to walk, "but staff don't have time." R11 stated, "I'm losing strength." R11 stated she could not recall the last time staff helped her walk.

During a telephone interview on 10/22/20, at 2:05

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p.m. family member (FM)-E stated R11 was not doing very well. FM-E stated, "To get them to find the time to help her...they're understaffed like everyone else and they don't have time." "FM-E could not confirm if R11 walked daily stating, "I doubt it, but I just don't know." FM-E stated, "They're overwhelmed and sympathetic, but I don't know what's happening there."

R11's care plan category called restorative nursing dated 3/25/20, indicated R11 required restorative program to address neuromyopthay (weakness, numbness and pain from nerve damage), osteoarthritis of both knees, and fibromyalgia (wide spread muscle pain) with decreased mobility. Goals and approaches indicated R11 would continue to ambulate 400 feet daily and use the NuStep 10 minutes daily between 6:00 a.m. and 2:15 p.m.

R11's point of care history report indicated the frequency of restorative nursing related to walking. The report indicated R11 ambulated zero times between 9/21/20 and 10/22/20. The reasons included: not observed, could not assess, deferred due to condition, unavailable and unknown.

During an interview on 10/20/20, at 4:45 p.m. nursing assistant (NA)-B stated she usually worked without taking a break as there was too much work to get done. NA-B stated there were only two aids to care for 30 residents, adding she had 15 residents by herself that morning. NA-B stated things that don't get done due to lack of staff included: dirty laundry, call lights, turning, walking, toileting. "I've seen lights on for an hour. It's stressful...I go home thinking about all the

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things I couldn't do." When asked if staff were able to provide restorative services to residents who require it, such as walking, NA-B stated, "I know it's not getting done. We don't have the staff or the time to do it." When asked how lack of restorative services might affect residents, NA-B stated, "They'll decline and that's not fair to them."

During an interview on 10/21/20, at 8:42 a.m. (NA)-C stated she had not been able to walk residents who are on restorative programs and stated "something has to give; we can't do it all." NA-C acknowledged that restorative services were important for residents stating, "it helps with balance and strength." NA-C stated she had brought this to the attention of the DON and the DON stated they were working on hiring more staff. NA-C stated they used to have a restorative aide, but that position was eliminated and now all nursing assistants are expected to provide restorative services, such as walking, along with their other responsibilities.

During an interview on 10/21/20, at 11:09 a.m. DON stated she had been instructing nursing assistants to complete a task and then document it in the electronic medical record (EMR) before moving on to the next task. DON explained this was important so that these tasks show up in the care history report as being done. DON stated some nursing assistants had been resistant to documenting these tasks in the EMR. DON acknowledged the staffing challenges of the facility and stated she recognized that care plan interventions, such as restorative serves were not being done. DON stated she did not have time to look at resident EMR's to determine if

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MADONNA TOWERS OF ROCHESTER INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

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F 688	Continued From page 52	F 688		

restorative services were being done according to the care plans. DON stated when she asked staff about whether restorative serves were being done, some nursing assistants said they were doing it, some said they didn't have time to do it, and some said they forgot to document it. DON stated it was the expectation staff provided services as indicated on care plans, but acknowledged there wasn't enough staff to do it.

During an interview on 10/22/20, at 11:07 a.m. corporate vice president of operations (VPO)-G stated, "in this industry, we are all staffing challenged, we are trying to ensure we have staff to meet the needs of our residents." VPO-G stated there was a culture issue at this facility and stated, "it's unfortunate where it's been allowed to go." VPO-G stated not being able to meet resident needs, was a combination of short staffing and how existing staff was working, adding "leadership needed to be on the floor and providing guidance." When informed staff reported they did not have time to walk residents who are on a restorative programs because they are too busy, VPO-G stated she was not aware of some issues until they rise to a certain level. Administrator added that a lot had happened at the facility with Covid19, changes in leadership, staff quitting, and trying to rebuild, adding "we staff some pretty good ratios" and resident care concerns were more related to staff inefficiencies.

Facility policy titled Restorative Program dated 2017, indicated:
Purpose: To ensure residents are comprehensively assessed / reassessed for restorative needs.
1. Restorative programs were established so that

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F 688	Continued From page 53 each resident can attain and maintain highest physical, mental and psychosocial well-being. Restorative nursing care promotes resident's highest level of independence in activities including daily living, range of motion, ambulation and bed mobility. 2. A registered nurse will provide oversight to the program to ensure the restorative interventions are being implemented as planned.	F 688		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725		12/4/20

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F 725	Continued From page 54 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient staff to provide and meet the assessed needs for 4 of 4 residents (R11, R12, R13, R14) who voiced concern with lack of sufficient staffing in the facility. The lack of sufficient staff had the potential to affect all 50 residents who resided in the facility. Findings include: R12 R12's facesheet, printed 10/23/20, indicated diagnoses of Parkinson's disease (disease affecting movement), age-related physical debility, osteoporosis (a condition in which bones become weak and brittle), muscle weakness and repeated falls. R12's quarterly Minimum Data Set (MDS) assessment dated 8/18/20, indicated R12 was cognitively intact, had adequate hearing, impaired vision requiring corrective lenses, clear speech, was understood and had clear comprehension. R12 required extensive assistance of two staff for bed mobility, transfers and toileting, and extensive assistance of one for dressing, walking in her room and locomotion on the off the unit. R12's care plan goal dated 9/3/20, indicated R12 would reach maximum rehabilitation potential and improve ability to perform activities of daily living (ADL's) for bathing, grooming, dressing, oral care. The care plan indicated R12 needed assistance with evening cares, toileting,	F 725	R11's care plan was reviewed and revised. R12's care plan was reviewed and revised. R13's care plan was reviewed and revised. R14's care plan was reviewed and revised. All residents who reside at Madonna Towers have the potential to be affected. "Resident Rights and Notification" policy was reviewed and remains current. "Comprehensive Assessments and Care Planning" policy was reviewed and remains current. "Concerns and Grievances" policy was reviewed and remains current. "BHS Restorative Program" policy was reviewed and remains current. Project scope worksheet has been completed for call light response time that includes the problem, the associate assigned to complete the PDCA and problem statement data based goal. 4 Call system implemented by 12/4/2020. Resident Council held on 11/19/2020. All restorative plans were reviewed and care plans revised as necessary. All licensed staff will be educated on the Comprehensive Assessments and Care Planning policy at the nursing staff trainings on 12/1 and 12/2. All nursing assistants will be educated on	

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F 725	Continued From page 55 incontinence care and ambulation. Staff responsible for these activities were identified as nursing assistants and nurses. During an interview on 10/19/20, at 10:58 a.m. R12 stated there was "not enough staff." R12 stated staff cannot always come when she puts her call light on and stated, "Nothing makes you feel more helpless at night when it's dark and no one comes." R12 stated, "Staff can't come right away because they can't leave the person they're working with." R12 stated, "They always put you on the toilet and say I'll be right back, but they aren't right back." R12 stated, "I'll be right back are their famous words." R12 stated, "I start out using my walker to get to the bathroom, but my kids say don't do that, I might fall." During an interview on 10/22/20, at 1:31 p.m. R12 stated, "If they walk me once a week, I'm doing good, and I do need it. I am getting weaker every day and I am not going to last long at this rate. I'm not active enough." R12 stated she would like to walk in the hallway. R12 stated that in the morning, she would ask staff if she could walk and staff say, "Later, but later never comes." R13 R13's face sheet, printed on 10/23/30, indicated diagnoses of ataxia (impaired balance or coordination), degeneration of nervous system (loss of function or structure of nerves of the spinal cord). R13's quarterly Minimum Data Set (MDS) assessment dated 9/29/20, indicated R13 was cognitively intact, had adequate hearing and vision, clear speech, was understood and had	F 725	the documentation of restorative plans and the use of the bathing preference form at the nursing staff training on 12/1 and 12/2. All nursing staff will be educated on the Resident Rights and Notification policy, the Concerns and Grievances policy, the BHS Restorative Program policy and the call light system at the nursing staff trainings on 12/1 and 12/2. Audits of customer concerns and call light response time will be completed 3x/week for 4 weeks. Audits of completion of restorative plnas and accompanying documentation will be completed 3x/week for 4 weeks. The facility will conduct resident interviews and care audits, with an emphasis on individualized care and preferences 3x/week for 4 weeks. Administrator/Designee is responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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clear comprehension. R13 required extensive assistance of one staff for bed mobility, transfers and toileting, locomotion on and off the unit, and walking in room or corridor occurred only once or twice.

R13's care plan goal dated 7/13/20, indicated R13 would continue to participate in activities of daily living (ADL's) while able. R13's care plan indicated R13 required assistance for bathing, brushing teeth, grooming, dressing, toileting, incontinence care and ambulation. Staff responsible for these activities were identified as nursing assistants and nurses.

During an interview on 10/19/20, at 2:09 p.m. R13 stated in the last 6 months, the facility had lost a lot of staff and staff morale was low. R13 stated, "I look at three things in order to rate staff: personality, efficiency and timeliness." R13 stated, "Most of the pool staff don't have any, don't treat us with respect and are not personable." R13 stated, "With pool staff, I wait a long time." R13 stated, "I used to wait 10 minutes and today I waited 40 minutes." R13 stated, "They are short staffed." R13 stated, "Management pushes them. A lot of staff are working double shifts." R13 stated, "I hate seeing good staff leave and just poor ones stay." R13 stated, "Personally, I have not suffered any consequences to having to wait for a call light to be answered...yet."

During an interview on 10/22/20, at 12:45 p.m. R13 stated they used to have two bath aides and now have only one. R13 stated this change negatively impacted her, adding when her nursing assistant (NA) had to give an evening

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bath, "she can't help me and apologizes she is not able to get to me sooner." R13 stated they used to have a restorative aid and was able to use the bicycle and walk in the hall, but now that they are short staffed, she doesn't walk. R13 stated the new management was more concerned about the bottom line than the residents. R13 stated, "I'm paying a lot of money to be here and they aren't always meeting my needs."

R11
R11's facesheet, printed 10/23/20, indicated diagnosis of dementia, age related physical debility, osteoarthritis and muscle weakness.

R11's quarterly Minimum Data Set (MDS) assessment dated 8/11/20, indicated R11 had moderate cognitive impairment, had adequate hearing and vision, clear speech, was understood and had clear comprehension. R11 required extensive assistance of one staff for bed mobility, transfers and toileting and locomotion on and off the unit. R11 required limited assistance of one when walking in room, and walking in the corridor with assistance of one staff occurred only once or twice.

R11's care plan goal dated 8/19/20, indicated R11 maintain current level of functional mobility with activities of daily living (ADL's). R11's care plan indicated R11 required assistance putting on compression stockings, bathing, oral care, grooming, dressing, toileting, incontinence care and ambulation. Staff responsible for these activities were identified as nursing assistants and nurses.

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During an interview on 10/22/20, at 1:52 p.m. R11 stated she wanted to walk, "but staff don't have time." R11 stated, "I'm losing strength." R11 stated she could not recall the last time staff helped her walk.

During a telephone interview on 10/22/20, at 2:05 p.m. family member (FM)-E stated R11 wasn't doing very well. FM-E stated R1 had accidents (soiled herself) quite a bit, and that upset her. FM-E stated, "To get them to find the time to help her...they're understaffed like everyone else and they don't have time." FM-E stated, "I've had to call the facility to ask them to help toilet her and it just falls on deaf ears." FM-E stated, "They're overwhelmed and sympathetic, but I don't know what's happening."

R14
R14's facesheet printed 10/23/20, indicated diagnoses of osteoarthritis (wearing down of bones), kyphosis (forward rounding of the back), obesity and muscle weakness.

R14's quarterly Minimum Data Set (MDS) assessment dated 10/6/20, indicated R14 was cognitively intact, had adequate hearing, impaired vision requiring corrective lenses, clear speech, was understood and had clear comprehension. R14 required extensive assistance of one staff for bed mobility, transfers, dressing and toileting. R14 required limited assistance of one when walking in room, and limited assistance of one with locomotion on the unit.

R14 care plan goal dated 10/15/20, indicated

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R14 would continue to participate in activities of daily living (ADL's) as able. R14's care plan indicated R14 required assistance with putting on and taking off compression stockings, bathing, oral care, dressing, grooming, toileting, incontinence care and ambulation. Staff responsible for these activities were identified as nursing assistants and nurses.

During an interview on 10/19/20, at 1:13 p.m. R14 stated there "absolutely was not" enough staff to meet her care needs. R14 stated, "I can have my light on and I've had to wait as long as 30 minutes." R14 stated, "I take prune juice, when I have to go I have to go, so I try and go by myself." R 14 stated, "I'm having to do things on my own that I'm not supposed to do." R14 stated, "This hallway doesn't have enough help and hasn't for most of the year I've been here; it's gone downhill terribly." R14 stated, "Staff is leaving; they don't like the amount of work they have to do and don't like mandated overtime." R14 stated when long call lights and staffing were brought up at resident council, "It got a bit heated and the administrator backed away from it and changed the subject, he didn't want to talk about it." R14 stated, "It was evident we weren't allowed to say much as he cut us off." R14 stated, "They say it's supposed to be our home, but it's far from it." R14 stated, "Feels like a war between the workers and whoever is running the show." R14 stated she heard this used to be a five star place but now it was considered only two stars.

During an interview on 10/19/20, at 10:29 a.m. nursing assistant (NA)-A stated, "There is not enough staff." NA-A stated staff starting leaving

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when the new administrator came because more work was added without enough staff. NA-A stated there used to be two bath aids for 60 residents, but one bath aid was taken away. NA-A stated random aids are now assigned to assist with baths on evening and weekends and this means there are less nursing assistants on the floor to assist residents and answer call lights.

During an interview on 10/19/20, at 2:21 p.m. trained medication aid (TMA)-A stated, "Staffing is different lately but nothing anyone can control" and that leadership was trying. TMA-A stated a few people have left and no one was applying for positions, adding there were a lot of pool staff, more than usual. TMA-A stated new staff were younger and the job was not what they expected. TMA-A stated, "It's easy to become a nursing assistant, but when they get into it, it's more than they bargained for." TMA-A stated there were a lot of open positions and a lot of chaos going on right now. TMA-A stated they were working short two nursing assistants this day. When asked what might not get done due to working short, TMA-A stated, "probably not get to residents very fast when they put their call lights on."

During an interview on 10/19/20, at 2:57 p.m. registered nurse (RN)-C stated at times that there was not enough staff. RN-C stated as the charge nurse, if the unit was not fully staffed with nursing assistants, he chipped in and helped them. RN-C added that made it challenging to get his work done, such as wound care, supervising the work of the nursing assistants and acting as a resource to them. RN-C felt they provided safe care, but added short staffing leads

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F 725	Continued From page 61 to burnout and staff turnover. During an interview on 10/20/20, at 9:42 a.m. (RN)-A stated most days they had enough staff. RN-A stated "it seems like it's been random lately." RN-A stated, "For nursing, it's been okay, but the nursing assistants are short." RN-A stated that sometimes the facility mandated a nursing assistant to stay longer or called staff in from home. RN-A stated for example, "the night shift nursing assistants have already worked 12 hours, so if they work more, it would be 16 hours." RN-A stated the DON wanted to hire agency staff and regular staff, but neither were available. RN-A stated when they are short nursing assistants she tried to help them with their work. During an interview on 10/20/20, at 11:30 a.m. the director of nursing (DON) acknowledged they can't find staff to fill positions. DON stated she received push back at the suggestion of not taking new admissions in order to decrease census for the staff they have. Even with the use of agency staff, DON stated they are not adequately staffed, yet had not seen negative outcomes such as falls, pressure ulcers or increase in incontinence. DON added they had seen an increase in self-transfers, but without an increase of associated falls. DON stated she felt it was like a ticking time bomb, stating something would eventually happen to a resident. According to the DON, there were daily meetings with human resources but stated "We aren't getting applicants and our current staff is burned out." DON stated they were down two nurse managers, so the nurse supervisor got assigned to resident care and the DON filled both the	F 725		

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supervisor role and the DON role. DON stated, "Staffing was taking all the focus, so nothing else is getting done." DON stated, "Staff just get done what they have to do that day; nothing is being improved." DON stated, "They can't provide the care residents deserve."

During an interview on 10/20/20, at 4:45 p.m. (NA)-B stated she usually worked without taking a break as there was too much work to get done. NA-B stated there were only "three long-timers left" and staff were quitting due to working conditions. NA-B stated they no longer got overtime after eight hours, so lost incentive to work extra, although she did sometimes. NA-B stated there were only two aids to care for 30 residents, stating she had 15 residents by herself that morning. NA-B stated things that don't get gone due to lack of staff included dirty laundry, call lights, turning, walking, and toileting. NA-B stated, "I've seen lights be on for an hour. It's stressful...I go home thinking about all the things I couldn't do."

During an interview on 10/21/20, at 8:42 a.m. (NA)-C stated staffing had been frustrating. NA-C stated, "We hire new staff, train them, and then they leave." NA-C stated, "Agency staff is on the schedule, but don't show up at the last minute." When asked what she was not able to do when pressed for time, NA-C stated, "Checking on my residents." NA-C stated she had not been able to walk residents who are on restorative programs and stated, "Something has to give, and we can't do it all." NA-C stated she had brought this to the attention of the DON and the DON stated they were working on hiring more staff. NA-C stated they used to have a restorative aide, but that

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F 725	Continued From page 63 position was eliminated and now all NA's are expected to do it along with their other responsibilities. NA-C stated, "It's almost impossible to walk residents too, there isn't time." During an interview on 10/21/20, at 4:30 p.m. human resources manager (HR)-D stated it was hard to fill nursing assistant positions even with substantial monetary bonuses for full time positions and for internal referral bonuses. HR-D stated they used to have an employee referral base, but current staff no longer tell friends and family about open positions, "they don't want them to come here and work short." HR-D stated they got applicants, but not qualified applicants. HR-D stated, "We get applications from nursing assistants who have worked at every long term care facility in town in the last three years, and we are the only place they haven't worked. That's a red flag." HR-D stated it was difficult competing with the local hospital. During the same interview, finance manager (FM-C) stated they were using a lot of agency staff, but workers do not show up. FM-C stated staffing was discussed at leadership huddle daily, they talk about who was being hired, who had resigned, where new hires were in orientation. FM-C stated as a corporation, they offer reimbursement tuition, loan forgiveness and bonuses. FM-C stated, "Corporate changed from an 8/80 work week to a 40 hour work week in July and "some staff lost incentive to pick up shifts." FM-C stated they were looking at ways to speed up the hiring process and ways to increase wages. FM-C stated, "Other nursing homes are in the same boat, it's an overbuilt market, too many beds and we are fighting for the same people." FM-C stated it was difficult to compete with local Best Buy and Hobby Lobby	F 725		

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F 725	Continued From page 64	F 725		

wages. FM-C stated they were considering putting individuals through a nursing assistant course, paying for the course and giving them a full time position.

During an interview on 10/22/20, at 11:07 a.m. corporate vice president of operations (VPO)-G stated, "In this industry, we are all staffing challenged, we are trying to ensure we have staff to meet the needs of our residents." VPO-G stated there was a culture issue at this facility and "It's unfortunate where it's been allowed to go." VPO-G stated not being able to meet resident needs was a combination of short staffing and how existing staff were working, stating "leadership needed to be on the floor and providing guidance." The administrator stated that a lot had happened at the facility with Covid19, changes in leadership, staff quitting, and trying to rebuild. The administrator stated, "We staff some pretty good ratios" and resident care concerns were more related to staff inefficiencies.

Facility policy titled Staffing and Daily Work Assignments dated 2018, indicated:
Purpose: to ensure staff provide cares in accordance with resident needs.
Policy: Sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. All nursing service personnel shall follow daily work assignment and perform assigned duties in accordance with professional standards of practice.
Procedure:
1. Staffing numbers and the skill requirements

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F 725	Continued From page 65 of direct care staff are determined by the needs of the residents basked on each residents plan of care. 2. Inquires and concerns relative to staffing should be directed to the administrator/designee. 3. Certified nursing assistants (CNAs) and trainees carry out their daily assignment in a profession manner and in accordance with established nursing procedures and protocols. Facility Assessment, dated 10/28/19, indicated: 1. Person-centered service and care offered based upon needs of those we serve. This included Quality of Care: ADL support, mobility assistance, bowel and bladder care and toileting support, and rehabilitation therapy. 2. Staffing is planned in advance and altered based upon census in all departments. In addition, staffing in nursing are altered based upon resident need and the number of admission and discharges.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		12/4/20

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F 755	Continued From page 66 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure resident's medications were available for administration per physician orders for 2 of 3 residents (R1 and R9) reviewed for medication errors. Findings include R1's Face Sheet provided by the facility on 10/23/2020, included diagnoses of hepatic failure, alcoholic cirrhosis of liver, diabetes type 1, dementia without behavioral disturbance, and constipation. R1's elimination care plan dated 8/4/2020, included is taking lactulose; goal of 2-3 bowel movements per day due to cirrhosis. R1's physician orders included: -Lactulose solution 30 ml three times a day for	F 755	R1's lactulose order was edited for indication for use hepatic failure on 10/23/20 and order remains active. R9 is no longer in the facility. All residents who reside at Madonna Towers have the potential to be affected. "Administering Medications" policy was reviewed and remains current. Alixa Pharmacy "Unavailable Medications" policy was reviewed and remains current. All licensed staff and TMAs will be educated on Administering Medications and Unavailable Medications policies on 12/1 and 12/2.	

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F 755	Continued From page 67 constipation (start date 8/19/2020). -Hydrocortisone 5 milligrams (mg); administer 1-2 tablets three times a day (start date 8/19/2020) -Glucosamine-chrondroitin 500-400 mg twice a day (start date 8/19/2020). R1's medication administration record (MAR) identified multiple doses of lactulose were not given related to the medication not available. -8/4/2020, MAR- one dose was not administered: drug/item unavailable. -8/5/2020, MAR - 3 of 3 doses were not administered: drug/item unavailable. -8/6/2020, MAR - 2 of 3 doses were not administered: drug/item unavailable. -8/30/2020, MAR - 2 of 3 doses not administered; drug/item unavailable. -9/15/2020, MAR - 1 of 3 doses not administered; drug/item unavailable. -9/27/2020, MAR - 2 of 3 doses not administered; drug/item unavailable. Hydrocortisone -10/7/2020, MAR - 1 of 3 doses was not administered: drug/item unavailable Glucosamine -Chrondoitin -8/22/2020, MAR- 2 of 2 doses were not administered: drug/item unavailable. R9 R9's Face Sheet provided by the facility on 10/23/2020, included diagnoses of essential hypertension, venous insufficiency, cirrhosis of the liver, Chronic kidney disease stage 3, rheumatic tricuspid insufficiency, and secondary pulmonary hypertension.	F 755	Audits of Electronic Medication Administration system "Administration Compliance Report" for med not available/no given will be completed 3x/week for 4 weeks. Administrator/Designee is responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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F 755	Continued From page 68 R9's physician orders included: -Amitriptyline 2%-ketamine 5% -lidocaine 2% in lipoderm cream, apply to bilateral knees 1 gram topically two times a day (Start date 9/28/2020). -Nystatin powder 100,000 unit/gram; one application four times a day (start date 9/21/2020) -Hydrocortisone cream 2.5% Mix 1:1 with Ketoconazole and apply to the effected area twice a day (start date 9/21/2020, stop date 10/3/2020) R9's medication administration record (MAR) identified the medicated cream/ointments were not available to administer per physician orders. Amitriptyline cream Medication administration record (MAR) on 10/5/2020, medication was not administered; drug/item unavailable. Nystatin MAR 9/21/2020, 2 of 4 application not administered; pharmacy won't send and drug/item unavailable. MAR 9/22/2020, 4 of 4 applications not administered; drug/item unavailable. MAR 9/23/2020, 1 of 4 application not administered; drug/item unavailable. MAR 9/28/2020, 2 of 4 applications not administered; drug/item unavailable Hydrocortisone cream MAR 9/21/2020, 2 of 2 applications not administered; drug/item unavailable new admit med unavailable, and pharmacy won't send. MAR 9/22, 9/23, 9/24, 9/25/2020, 2 of 2 applications were not administered; drug/item	F 755		

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F 755	Continued From page 69 unavailable MAR 9/26/2020, 1 of 2 applications not administered; drug/item unavailable. MAR 9/27/2020, 1 of 2 applications not administered; drug/item unavailable MAR 9/30/2020, 1 of 2 applications not administered; drug/item unavailable. MAR 10/2/2020, 1 of 2 applications not administered; drug/item unavailable. During an interview on 10/19/2020, at 9:37 a.m. trained medication assistant (TMA)-B stated if a medication was not available then then supposed to let the nurse know; if it's not ordered then we are supposed to order it. TMA-B indicated an unawareness if it was considered a medication error if the medication was not available from pharmacy. During an interview on 10/20/2020, at 11:16 a.m. director of nursing (DON) indicated if medications were not available for administration, it was considered a medication error. The DON stated a medication error report should have been completed, the physician should have been notified, and the pharmacy contacted. During an interview on 10/21/2020, at 2:35 p.m. Allixa pharmacy technician (PT) stated medications were delivered to the facility, if there was a medication not available then staff would just give when the medication was available. PT confirmed pharmacy delivery services were available 24/7, however facility staff would have to communicate they wanted the medication immediately. PT stated if the pharmacy did not have the medication, facility staff should notify the physician; omission of medication was	F 755		

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considered medication error.

During an interview on 10/22/2020, at 9:34 a.m. licensed practical nurse (LPN)-A stated if a medication was not available it was considered a medication error and the nurse should be notified. LPN-A indicated the pharmacy should be contacted. LPN-A stated if the primary pharmacy did not have the medication then we would call the back-up pharmacy.

10/23/2020, at 8:30 a.m. director of nursing (DON) stated if a medication was not available for administration then the physician needed to be notified. DON stated the facility had a 24/7 pharmacy and a back-up pharmacy; medications should be available for administration when they are scheduled.

During a return phone interview on 10/29/2020, at 3:30 p.m. with nurse practitioner (NP)-B, NP-B indicated an expectation medications were at the facility for administration per physician order and expected to be notified the medication was not available. NP-B indicated an unawareness that R1's lactulose was not administered because it was not available.

The Accepting Delivery of Medications policy dated 9/2018, included 2. The nurse reconciles the medication delivered against the pharmacy order listing/ticket. 3) If any discrepancies are noted the nurse notifies the pharmacy. Nurse will follow the directions of the pharmacy for correcting any error ...Documentation will be completed on the pharmacy order ticket. 6. Appropriate notifications completed if medication errors occur.

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F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R1 and R4) reviewed for diabetic management were provided adequate diabetic care in accordance with current standards of practice. This practice, including inaccurate insulin administration, inadequate monitoring and notification of the physician, resulted in an immediate jeopardy situation for R1. The immediate jeopardy began on 8/5/20, when R1 required emergent care due to hypoglycemia (low blood glucose level) due to a failure of the staff to monitor and assess the resident's diabetic status and was identified on 10/21/20. The administrator, director of nursing, interim infection preventionist, and culinary director were notified of the IJ on 10/21/20, at 12:45 p.m. The IJ was removed on 10/22/20, at 5:45 p.m., but non-compliance remained at a lower scope and severity level of G, a pattern with actual harm but is not immediate jeopardy. In addition, the facility failed to ensure appropriate indication for Lactulose and failed to administer per physician orders for 1 of 3 residents (R1) reviewed for medication errors. Findings include: R1's Face Sheet, included diagnoses of type 1	F 760	R1's orders have been reviewed and are regularly reviewed by providers and the diabetic order set with monitoring was added. R4's orders have been reviewed and are regularly reviewed by providers and the diabetic order set with monitoring was added. All residents residing at Madonna Towers have the potential to be affected. "Change in Condition" policy reviewed and remains current. "Administering Medications" policy reviewed and remains current. "Medication Error/Occurrence" policy reviewed and remains current. Licensed nursing staff, as part of the abatement plan were reeducated on the facility's insulin administration protocol with emphasis on blood sugar monitoring and meal intake. Meal intake has been added for diabetic residents and nursing orders to monitor for hyper/hypoglycemia and emergency protocols. Licensed nursing staff, as part of the abatement plan were educated on signs/symptoms of hypoglycemia as well as hyperglycemia. Licensed nursing staff will be educated on	12/4/20

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F 760	Continued From page 72 diabetes, hepatic [liver] failure, alcoholic cirrhosis of the liver and dementia without behavioral disturbance. R1's admission Minimum Data Set (MDS) assessment dated 8/7/20, indicated R1 had severe cognitive impairment, was independent with eating, and required insulin. MDS dated 8/24/20, indicated, R1 required one person physical assist and supervision for eating. R1's diabetic care plan revised on 8/27/20, indicated R1 had type 1 diabetes that required insulin. R1 goals included, "Will have no complications r/t [related to] diabetes and blood glucose will remain within prescribed parameters". Corresponding interventions included, administered diabetes medications as ordered, monitor blood glucose as ordered, and observe for any signs/symptoms of hypo/hyperglycemia (low/high blood sugar reading). R1's nutrition care plan revised on 10/19/20, directed to document meal intake %, and indicated R1's intake was 0-50% of meals and required cuing and encouragement (10/19/20). During observation on 10/19/20 at 4:30 p.m., R1 was observed to sit alone in his room in his wheelchair with tray table in front of him, with Oreo cookies taken apart. R1 stated he was a diabetic and often times his blood sugar was low, and he did not think he could tell when he was low. R1 was not able to articulate if he had already received his insulin before the evening meal, and could not articulate if he usually received insulin before or after meals.	F 760	the facility's insulin administration protocol and signs/symptoms of hypo/hyperglycemia at the nursing staff trainings on 12/1 and 12/2. Licensed nursing staff will be educated on the Change in Condition, Administering Medications, which includes indication for use and the Medication error/Occurrence policies at the nursing staff trainings on 12/1 and 12/2. Audits of blood sugar values and insulin administration records will be completed 5x/week for 4 weeks. Symptom recognition and insulin administration audits will be completed 5x/week doe 4 weeks with EMR reporting function - "Facility Activity Report" and "Administration Compliance". Audits of medication orders for indication for use will be completed 5x/week for 4 weeks. Administrator/Designee is responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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F 760	Continued From page 73 R1's current physician orders included: -Fragile diabetic. Monitor blood glucose at 2:00 a.m. Provide snack as needed (start date 9/14/20) -Blood sugar checks four times a day at 6:00 a.m., 11:00 a.m. 4:00 p.m. and 8:00 p.m. (start date 8/4/20, stop date 8/5/20)- then 8/19/20 to current. -Offer assistance with meals (start date 8/23/20, to current) Novolog aspart u-100; administer 12, 6, and 7, hold insulin aspart if not eating (start date 9/2/20) -Novolog aspart sliding correction scale for blood sugars above 200 mg/dl, three times a day at 8:00, 12:00 p.m. and 5:00 p.m. (start date 8/19/20) -Lantus U-100 pen; administer 24 units in the morning and 12 units at bed time (start date 8/19) Facility Standing House Orders for Symptom Management dated 3/20, included orders for diabetic management. -administer short-acting insulin < 15 minutes before a meal due to rapid onset of action. Hypoglycemia: -If patient is symptomatic, conscious and able to swallow: administer 6 oz. (ounces) of fruit juice, regular pop or other high carbohydrate beverage. Repeat BG (blood glucose) after 10 minutes (min); if < 70, repeat intervention, if after 2 attempts to treat and BG is still <70, notify provider. If patient is unresponsive or unable to swallow: administer glucagon 1 mg (milligram) IM (intramuscularly). Repeat BG after 10 minutes; if <70 and patient still unresponsive, unless contrary to advance care plan-call 911 and notify provider immediately. If BG remains <70 but	F 760		

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patient is conscious, initiate interventions for the conscious patient. Once patient is stable, recheck BG after 60 minutes. Communicate occurrence of any hypoglycemic event to provider the next business day.

R1's hospital After Visit Summary dated 8/4/20, included "Monitor blood glucose 5 times daily, bed time and 0200 [2:00 a.m.] (To monitor for hypoglycemia.) Blood glucose goal is 120-180 mg/dl (milligrams per deciliter) higher glucose goal due to advanced age."

A review of R1's blood sugar record in conjunction with R1's medication administration record (MAR), nursing notes and assessments were reviewed from 8/1 to 10/19/20. R1's record identified blood sugars below 80 mg/dl. R1's record did not always include a reassessment of interventions when readings were low. In addition, R1's record lacked monitoring for signs/symptoms of hypoglycemia. Further, R1's record included documentation of "late administration" of insulin and blood sugar checks, and failed to demonstrate R1's physician was not notified per physician orders or per facility standing orders.

Progress notes on 8/5/20, at 5:09 p.m. BS was 76 mg/dl, the MAR (medication administration record) indicated "late administration: low prior, gave OJ (orange juice)".

Progress note dated 8/5/20, at 5:57 p.m. indicated R1 was asymptomatic, offered snacks and supper, physician was notified which resulted in an order to give half of the scheduled dose insulin and continue to monitor. No record

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F 760	Continued From page 75 of re-evaluation/monitoring per physician orders. On 8/7/20, at 12:29 BG was 112 mg/dl, and Aspart insulin 20 units was administered. At 5:35 p.m. BS was 33, gave glucagon (injection to quickly increase blood sugars) per order and supper. R1's corresponding progress note at 9:04 p.m., included "Resident BS checked at 4:30 p .m. and was 33." The note indicated PRN glucagon was administered, R1 was lethargic, staff assisted him with dinner, and checked BS went up to 62, after the meal it went up to 72, and before bed BS was 291. The record indicated the provider was notified. R1's telehealth physician visit dated 8/7/20, indicated physician reviewed blood sugars and gave new orders for insulin. The note also referenced blood sugar goal range of 120-180 mg/dl. On 8/8/20, at 4:00 p.m. BG was 68 mg/dl. offered orange juice. The progress note identified the BS was checked 30 minutes later however the BG record, was not consistent with the progress note. The BG record read 452 mg/dl at 8:16 p.m. and at 9:45 p.m. was 430 mg/dl. Furthermore, the progress note indicated the recheck was completed 30 minutes later rather than 15 minutes per order, and did not include signs and symptoms of hypoglycemia. On 8/9/20, R1's BG record indicated, BG was taken late at 10:12 a.m. and was 289, at 12:28 p.m. BS was 470 mg/dl. On 8/11/20, BG at 10:53 a.m. was 193, meal intake was not recorded, MAR indicated R1	F 760		

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administered Aspart 10 units. At 5:35 p.m. R1's blood sugars was documented as 27 mg/dl, 140 mg/dl, and 70 mg mg/dl. Corresponding progress note at 8:29 p.m. included "Resident blood glucose at 1600 [4:00 p.m.- inconsistent with recorded time on BG log] was 27 mg/dl other vitals were stable. Resident was symptomatic, positive shakiness, sweating, confused, and drowsy. Standing order glucagon 1 mg IM given. After 15 minutes rechecked, 140 mg/dl. Resident was closely monitored, after 30 minutes checked again and it was 70 mg/dl resident was conscious. On call doctor updated and order to give additional glucagon if resident is unable to swallow." The note indicated R1 was offered orange juice with supper, and consumed 75% of meal. After 30 minutes rechecked and BS was 116 mg/dl. At 8:00 p.m. BS was 251 mg/dl.

On 8/12/20, BS at 10:53 a.m. was 118 mg/dl, meal intake was recorded at 50%, MAR indicated 8 units of Aspart was administered. At 4:42 p.m. BS was 61 mg/dl. Corresponding progress note at 8:06 p.m. included "BG check at 3:30 [inconsistent with recorded time on BS record]. Resident semi alert and was able to swallow fluid. 2 ensure supplements given. BS recheck @ 125. Resident regained his consciousness." The note indicated R1 was responsive the rest of the shift. The note did not identify when BS was rechecked.

On 8/13/20, at 3:10 p.m. BS was 69 mg/dl., meal intake was not recorded. R1's record lacked evidence of intervention and monitoring for signs and symptoms of hypoglycemia.

R1's telehealth physician visit note dated 8/13/20,

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F 760	Continued From page 77 indicated physician reviewed blood sugars and made adjustments to insulin based on high blood sugars in the morning and bedtime reading of 200-300. R1's MAR indicated on 8/15/20, the 4:00 a.m. scheduled oral hydrocortisone was not administered: "would not wake up for meds". On 8/15/20, R1's meal intake for lunch and dinner intake was not recorded however, progress note at 1:57 p.m. indicated R1 required encouragement and "only ate about 50%". BS was checked at 12:02 p.m. and was 269 mg/dl, MAR indicated Aspart 9 units was administered late at 1:48 p.m. The record did not identify a BS recheck prior to the administration of insulin. At 4:54 p.m. BS was 20 mg/dl, at 4:55 p.m. BS was 37 mg/dl, at 4:57 p.m. BS was 41 mg/dl, and at 5:15 p.m. BS was 20 mg/dl. Corresponding progress note at 6:53 p.m. included "around 4:15 p.m. [time is inconsistent with recorded time on BS record] to check scheduled blood glucose, resident was unconscious and sweating" Check right away and blood sugar and it was 20 mg/dl and other vitals were stable. Administered STAT glucagon IM as standing order. After 10 minutes still unconscious and blood glucose was 37 mg/dl. Administered another dose of glucagon 1 mg IM as standing order. After 5 minutes blood glucose was 41 mg/dl. Called 911 around 4:35 p.m. and paramedics arrived approximately 4:40 p.m. Prior to arrival of paramedics resident was starting to make movements opened his eyes but still weak. Resident transferred to the ER around 1650 [4:50 p.m.]." R1's MAR did not include the administration of glucagon.	F 760		

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R1's hospital After Visit Summary (AVS) dated 8/15/20, presented to the emergency room "unconscious due to severe hypoglycemia in the setting of medication misadministration. "He was found on 8/15 with a blood glucose of 20. He received 2 doses of glucagon prior to EMS arrival with minimal improvement (up to 40 then 50). EMS administered ½ amp of D50 (an ampule of 50% glucose) with improvement of blood glucose to 120. BG on arrival to ED was 116. Per EMS report, patient has had repeated episodes of hypoglycemia lately. He was hemodynamically stable and shivering on arrival to the ED...In regards to the patient's episode of hypoglycemia, the collateral history collected by [name of doctor] in Endocrinology reveals that the patient did not eat lunch but he was still given insulin. Additionally, he had skipped his morning hydrocortisone. Both of these incidents could have precipitated his hypoglycemic episode." The summary indicated R1's hypoglycemia resolved and his insulin regimen was adjusted to help with better control of hypoglycemia.

R1's telehealth physician visit note dated 8/20/20, referenced R1's causal factors of hypoglycemic event on 8/15/20. The note indicated R1 was sleepy in the morning, difficult to administer hydrocortisone, and "while inpatient, there was also a strong pattern of him completing 100% of meal when his wife was present and only 25% of his meals when his wife was not there." No adjustments were made to insulin.

R1's telehealth visit dated 8/24/20, indicated physician reviewed blood sugars and did not make any adjustments related to significant hypoglycemic event. Indicated plan was follow up

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next week when "we have reliable oral intake. Orders to hold insulin if not eating."

On 8/26/20, at 7:15 p.m. BS was 195 mg/dl, meal intake record had 2 different intake amounts for dinner; 51-75% and 76%-100 and did not identify R1 was administered a bedtime snack. MAR identified Aspart 9 units was administered as scheduled before dinner. On 8/27/20, at 1:16 a.m. BS was 54 mg/dl. MAR indicated R1 was asymptomatic, apple juice with sugar, vanilla pudding, and peanut butter crackers were provided. Corresponding progress note included "Resident's blood sugar at 12:50 a.m. [inconsistent with recorded BS record] was 54 mg/dl. He was alert and talking. HS [bedtime] snack provided." The note indicated R1's blood sugar was not checked until one hour later at 1:50 a.m. when blood sugar was 159 mg/dl.

On 8/31/20, at 10:50 a.m. BS was 70 mg/dl, MAR included "nurse aware, gave OJ"; insulin was not administered. Record lacked evidence of recheck of BS after OJ and monitoring for signs/symptoms of hypoglycemia.

On 9/3/20, at 11:39 a.m. BS was 65 mg/dl, MAR indicated insulin was not administered. Record lacked interventions, recheck, and monitoring for signs/symptoms of hypoglycemia.

On 9/7/20, at 12:04 a.m. BS was 58 mg/dl; next recorded BS was 4:06 a.m. was 295 mg/dl. Meal intake record did not identify R1 had a snack before bed. According to the MAR glucagon was administered at 12:14 a.m. Progress note at 5:05 a.m. included, "resident BS 58 at midnight check, gave PRN glucagon per order and BS went up to

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83. Gave milk and chocolate pudding and recheck BS after. Went up to 183. No visible signs of hypoglycemia."

R1's physician telehealth visit note dated 9/8/20, referenced low BS readings, 64 on 9/3 and 58 on 9/6. Note further indicated no adjustments would be made to insulin because of highs and lows. The note directed for nursing to continue administering insulin per orders and, "Nursing to continue to monitor patient closely, notifying NP/PA/MD if BS <80. Review blood sugars weekly."

On 9/15/20, at 7:02 a.m. BS was 60 mg/dl. MAR indicated insulin was held and R1 was administered peanut butter cookies, and orange juice with sugar. Progress note at 12:14 p.m. included, "BG at 0600 was 60. He was given OJ with 3 sugar packets and ate a good breakfast." The note also indicated R1's blood sugar prior to lunch was 436 mg/dl. The note did not identify that R1's blood sugar was retaken and that R1 was monitored following the interventions.

R1's record lacked evidence the physician was notified of blood sugar below 80.

R1's progress note on 9/18/20, at 12:49 a.m. indicated R1 was found sitting on the floor; the record did not identify R1's blood sugar was taken. At 3:06 a.m. BS was 74 mg, meal intake record did not identify R1 had a bed time snack. Progress note at 3:00 a.m. included, "BS at 0300 [3:00] was 74. Orange juice with some sugar added was given. Recheck at 0400 [4:00] and was 131." The MAR indicated 6:00 a.m. blood sugar was 139, meal intake was not recorded,

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and R1 was administered Aspart 12 units. BS at 12:07 p.m. was 52 mg/dl, at 1:55 p.m. 144 mg/dl, and at 1:55 p.m. was 66 mg/dl. Progress note at 1:56 p.m. indicated at 11:00 a.m. (time is inconsistent with blood sugar record) was 52, "resident was semi alert with stimuli. OJ and ensure given prior to lunch. BG recheck at 66. Staff was assisting with lunch with >50% intake. Recheck BG 144 post lunch. Resident is alert."

On 10/5/20, MAR 4:00 p.m. was 273, meal intake record did not identify R1's intake for dinner, R1 was administered Aspart 11 units and was documented late at 8:07 p.m., it's not evident what time the insulin was administered. At 7:36 p.m. BS was 64 mg/dl and Lantus insulin was held. Corresponding progress note at 8:06 p.m. Included "Resident's BG at evening was 64 mg/dl. Asymptomatic. Offered snacks and will check BG after 15 minutes. The record lacked evidence of snack intake, or R1's BS was rechecked.

R1's record lacked evidence the physician was notified of blood sugar below 80.

On 10/12/20, at 7:23 p.m. BS was 175 mg/dl, meal intake record did not identify R1 had a bed time snack. On 10/13/20, at 2:20 a.m. R1's BS was 68 mg/dl. R1's record lacked evidence of interventions, and monitoring for signs and symptoms of hypoglycemia.

R1's record lacked evidence the physician was notified of blood sugar below 80.

On 10/14/20, at 4:15 p.m. BS was 78 mg/dl, the MAR indicated insulin was "held". Meal intake

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indicated R1 ate 1-25% of food. Corresponding progress notes indicated R1 ate <50% of dinner, did not eat well, insulin was held. The record lacked evidence of rechecks of BS and monitoring for sings/symptoms of hypoglycemia.

R1's record lacked evidence the physician was notified of blood sugar below 80.

On 10/16/20, at 10:30 a.m. BS was 183, meal intake record did not identify R1's intake for noon meal. MAR indicated R1 was administered Aspart 6 units. At 4:15 p.m. BS was 67, and at 4:44 p.m. BS as 88 mg/dl, insulin was held. Corresponding progress note at 10:03 p.m. included "Res BS at 4:00 p.m. was 67. Gave snacks and resident ate 25% of his meal. BS went up to 88. BS 180 at HS [bed time], resident did receive snack". Record lacked evidence of rechecks according to order and monitoring of signs/symptoms of hyperglycemia.

R1's record lacked evidence the physician was notified of blood sugar below 80.

During an interview on 10/20/20, at 11:16 a.m. the director of nursing (DON) stated the facility did not have individual glucometers, but rather a house glucometer was used. The DON stated an unawareness of R1's hypoglycemic events, and stated an analysis or investigation was not completed to ascertain possible causal factors of the hypoglycemic events. The DON indicated having discussion with nurse practitioner about the R1's hypoglycemia thought to be a meal intake concern. The DON stated not all staff were educated, only staff involved were provided education. The DON stated she had reviewed

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R1's record and verified there was a time gap between the administration of insulin and time 911 was called. The DON stated blood sugars are supposed to be checked half hour before meals, and up to 30 minutes prior to aspart insulin administration. She stated blood sugars and insulin administration needed to be entered at the time of administration, and if blood sugar is low there should be rechecks completed every 15 minutes until safe range, monitoring for hypoglycemia/hyperglycemia, with physician notification per orders. The DON stated all information was supposed to be documented in a progress note

During an interview on 10/20/20, at 11:39 a.m. registered nurse (RN)-A, stated she took R1's blood sugar at 10:40 a.m., blood sugar was 197 mg/dl, she did not administer insulin, and would when he got his lunch tray. RN-A stated his lunch tray would be delivered around 11:45 a.m. RN-A indicated R1's blood sugar would not be retaken even though it was obtained over an hour before insulin would be administered.

During an interview on 10/20/20, at 4:00 p.m. licensed practical nurse (LPN)-B indicated blood sugars are taken when they are scheduled, aspart was supposed to be administered with the meal, and if BS low supposed to use interventions and recheck every 15 minutes.

During an observation and interview on 10/20/20 at 4:05 p.m. RN-E stated blood sugars had already been obtained. RN-E stated R15's blood sugar was taken at 3:23 p.m. and was 189, RN-E administered short acting insulin to R15 at 4:30 p.m., R15's meal tray arrived at 4:58 p.m. RN-E

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stated R16's blood sugar was at around 3:30 p.m. was 199, RN-E administered R16's aspart 6 units was administered at 4:50 p.m. with meal tray delivery.

During an interview on 10/22/20, at 9:23 a.m. NA-C stated meal intakes didn't always get recorded because different staff are assisting with meals and collecting trays. NA-C stated staff would put the tray in front of R1 to see if he would eat by himself but otherwise required assistance with eating, R1 would take a bite then stop. NA-C stated R1 had low and high blood sugars, when he was low he acts different, he would fall asleep. NA-C stated R1's blood sugar would be taken before meals however, unaware of how long before meals.

During an interview on 10/22/20, at 9:56 a.m. NA-F stated meal intake was supposed to be documented but didn't always do it. NA-F stated NA's were aware of who were diabetics because they had to wait to give residents trays until after they had their blood sugar checked and the residents got their insulin. If the blood sugar is low the nurse would tell us what to give the resident to eat.

During an interview on 10/22/20, at 9:34 a.m. licensed practical nurse (LPN)-A stated rapid acting insulin should be administered 15-30 minutes before the meal. LPN-A indicated if blood sugar was on the lower side before the meal, then the insulin dose and blood sugar should be evaluated, and held if resident not eating.

During an interview on 10/29/20, the nurse

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practitioner (NP)-B verified familiarity with R1 and hypoglycemic events. NP-B indicated R1's blood sugars obtained by the facility are not reflective in his A1C. NP-B indicated she had difficulty getting information from the facility, such as meal intakes. NP-B stated thought that R1's hypoglycemia was a result of not finishing his meal and that he required assistance, however that information had not been reported by facility nursing staff. NP-B indicated if the blood sugar was not checked close to meal times and insulin was administered based off the blood sugar and dependent on how much time had elapsed and when the resident ate, could cause hypoglycemia. NP-B stated aspart insulin should not be administered before 15 minutes prior to a meal- if not with the meal. NP-B indicated documentation should be done immediately after the medication was administered. If the timing of blood sugar checks, insulin administration, and meal intake are not completed accurately, it makes it difficult to make adjustments to insulin doses. NP-B stated parameters for notifications are written for each resident, staff should be notifying the physician per order or per the standing orders. NP-B stated physician's orders for hypoglycemia should be followed; rechecks done after 15 minutes until normal, in addition to continued monitoring for hypoglycemia when the sugars are low. NP-B stated an expectation that documentation be completed of the interventions and response to the interventions.

The IJ which began on 8/5/20, was removed on 10/22/20 at 5:45 p.m., when implementation of an acceptable plan of correction could be verified which included: The facility identified other residents at risk with potential to be affected,

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re-evalutaion of R1's blood sugars was conducted by the provider again on 10/22/20, with updates to R1's plan of care made. In addition all licensed nursing staff were re-educated on the facility's insulin administration protocol with an emphasis on blood sugar monitoring, and meal intake as well as education on signs and symptoms of hypo/hyperglycemia. Finally, the facility developed and implemented an auditing system to ensure ongoing compliance.

R4 INSULIN

R4's annual Minimum Data Set (MDS) dated 8/3/20, indicated R4 did not have cognitive impairment and was independent with eating. The MDS also indicated R4 required insulin.

R4's care plan dated 8/6/20, identified R4's diagnosis of diabetes and R4 had unstable blood sugars. The interventions included; monitor blood glucose as ordered, instruct resident on importance of not skipping meals and snacks, monitor/document/record any signs/symptoms of hyper/hypoglycemia.

R4 submitted a grievance on 9/9/20 at 9:00 a.m. The grievance included, "Resident was in the coffee area when [name of staff] walked by. She said "I still haven't gotten my breakfast and my insulin was given to me over an hour ago." She states staff told her breakfast would be right in. [Staff name] didn't know the details but went to get resident breakfast immediately." Findings and following up included, "The culinary staff had not received her menu yet" and "Nurse administered breakfast and lunch insulin late and without

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food." Actions: re-educated nurse and completed med error report.

During an interview, on 10/20/20, at 12:17 a.m. R4 sat in her room in her wheel chair. R4 stated nurses don't administer her insulin the right way; with meals. R4 stated she had filed a grievance in early September but couldn't remember the date. R4 stated she waited over an hour for her breakfast tray after she was administered insulin, and had to tell staff she didn't get her breakfast. R4 then stated her noon insulin was also a couple of hours late, and in the middle of the night her blood sugar was in the 50's. R4 stated she was tired of telling staff how to administer insulin.

Medication and Treatment Incident Report dated 9/9/20, did not identify the administration of insulin prior to breakfast as a medication error. The report identified 5 units of aspart insulin was given at the wrong time on 9/9/20 at 3:30 p.m. The report indicated the medication was not administered until 3:53 p.m. The report also included, "Insulin to be administered with or just prior to food. Nurse re-educated."

R4's physician orders included:
-Novolog Flex Pen U-100 aspart insulin; Administer 3 units with morning meal, 5 units noon, and 7 units at evening meal. HOLD IF NOT EATING, or BG <100. Give mealtime Novolog at the end of each meal so the dose can be reduced if she can not eat as much. Allow patient to ask staff to reduce dose of her mealtime Novolog based on activity or Oral intake. Patient should not be allowed to increase the dose of mealtime Novolog. (Start date 8/27/20, stop date

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F 760	Continued From page 88 9/28/20. -Tresiba FlexTouch Pen U-100 (insulin degludec) administer 21 units every morning (start date 8/5/20, stop date 10/16/20) -Insulin aspart; amount to administer; per sliding scale; if blood sugar is 200 to 250- give 1 unit, if 251 to 350- give 2 units, If 351 to 400-give 3 units, if greater than 400- give 4 units, and if over 500, call the physician. Provide correct post meals correction as follows three times a day: Below 80: subtract 2 units from meal dose. 80-100 subtract 1 unit from meal dose. 101-200 give only meal dose (start date 3/4/20). R4's blood sugar record was reviewed; the record identified on 9/9/20, at 7:32 a.m. and at 7:35 a.m. R4's recorded blood sugar was 193. -On 9/9/20, at 12:16 p.m. recorded BS was 113 mg/dl. -At 4:41 and at 5:23 p.m. recorded BS was 270 mg/dl -At 6:19 p.m. recorded BS was 113 mg/dl -At 7:00 p.m. recorded BS was 227 mg/dl R4's Medication administration record (MAR) indicated the morning of 9/9, R4 Tresiba (is a long-acting insulin used to control high blood sugar in adults) 21 units at 7:35 a.m. and Aspart 3 units was administered on time; the MAR did not indicate the doses were administered late or given after 9:00 a.m., when R4 reported she had not had her breakfast. R4's MAR on 9/9/20, identified the lunch dose of Aspart 5 units was administered late at 3:43 p.m. The MAR identified the 5:00 p.m. dose of aspart 5 units was administered late at 6:20 p.m. plus aspart 3 units per correction sliding scale.	F 760		

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A Hypoglycemia Event Report dated 9/10/20, at 3:37 a.m. indicated R4's blood sugar at 2:05 a.m. was 50, "insulin aspart 5 units given late at 3:35 p.m. and 8 units given at 6:20 p.m. Tresiba 21 units given at 7:35 a.m." with symptoms of confusion/mental lapse, weakness/fatigue, impaired speech, cold and clammy. Interventions included; glucagon injection, glucose tab, fruit juice; the interventions were effective.

R4's record lacked identification of the insulin medication errors and/or evidence monitoring for hypoglycemia as a result of late administrations.

R4's progress note dated 9/10/20, at 3:33 a.m., included, "Resident's blood sugar was 50 mg/dL at approx. 0205. She was lethargic with eyes closed and wasn't responding when spoke to or touched. Skin was clammy to touch. Glucagon 1 mg IM injection retrieved from e-kit and was given in left deltoid. at 0220. At 0225 her blood sugar was 69 mg/dL and was still difficult to arouse. At 0233 she started to wake up and was able to chew a glucose tablet and drink some OJ with 2 added sugar packets. At 0240 her blood sugar was 113 mg/dL. At 0300 blood sugar was 197 mg/dL. I was able to have a conversation with her and she stated she felt better"

During an interview on 10/20/20, at 11:00 a.m. licensed social worker (LSW)-A stated she took R4's grievance on 9/9/20, stated R4 had been yelling out and staff member asked what was wrong. LSW-A stated the staff member identified that R4 had not gotten her food prior to insulin administration, the meal order had been misplaced. LSW stated she brought the concern to the DON.

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During an interview on 10/20/20, at 11:16 a.m. director of nursing (DON) confirmed R4 had been given insulin after her meals. DON indicated a medication error report was filled out, and the nurse was provided education. DON stated the nurse who made the medication error, resigned her position after she was provided with education on proper insulin administration.

R1 LACTULOSE

R1's Face Sheet included diagnoses of hepatic failure, alcoholic cirrhosis of liver, diabetes type 1, dementia without behavioral disturbance, and constipation.

R1's After Visit Summary (AVS) dated 8/4/20, indicated while R1 was hospitalized blood Ammonia levels were 89, "Lactulose was started for concern of hepatic encephalopathy. Cognition improved during the hospital course, so we will continue lactulose at discharge." The discharge summary indicated R1 was not a transplant candidate at this time. The AVS included the order "lactulose 10 gram/15 milliliters (ml) solution, take 30 ml by mouth three times a day. Goal is for 2-3 BM [bowel movements] per day."

R1's elimination care plan dated 8/4/20, included is taking lactulose; goal of 2-3 bowel movements per day due to cirrhosis.

R1's physician orders included; Lactulose solution 30 ml three times a day for constipation (start date 8/19/20).

R1's medication administration record identified

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multiple doses of lactulose were not given related to the medication not available or held for loose stools. The MAR was reviewed in conjunction with R1's bowel movement record (BMR); the records identified multiple doses of lactulose were not given related to medication unavailable, inappropriately held for loose stools, not meeting goal of 2-3 bowel movements per day and/or resident refusals without evidence of re-attempts and physician notification.
8/4/20, MAR- one dose was not administered; drug/item unavailable.
8/5/20, MAR - 3 of 3 doses were not administered: drug/item unavailable. BMR: none (no bowel movements)
8/6/20, MAR - 2 of 3 doses were not administered: drug/item unavailable. BMR: one large bm.
On 8/7/20, BMR one large bm.
On 8/8/20, BMR; none
8/9/20, BMR; had two large bm's
8/10/20, MAR - 3 of 3 doses were not administered related to "one loose bm yesterday" and "XL [extra large] bm yesterday", and "on hold". BMR: none
8/11/20, MAR - 1 of 3 doses was not administered: Held "due to condition". BMR; none
8/12/20, BMR; none
8/13/20, MAR - 1 of 3 doses was not administered: on hold medium loose bm. BMR; 2 medium and large bm

R1's physician visit note dated 8/13/20, included "Patient also has history of hepatic encephalopathy. He has orders for lactulose to be given 3 times daily with goal of having 2-3 bowel movements daily. Patient is not having daily bowel movements. The lactulose is not

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F 760	Continued From page 92 being administered on a regular basis and is sometimes held when the patient has a loose stool. 8/14/20, BMR; one large loose bm. From 8/15/20 to 8/18/20, BMR did not identify any documentation 8/21/20, MAR - 1 of 3 doses was not administered: due to condition. BMR; one large bm. 8/22/20, BMR- one large bm 8/23/20, MAR -1 of 3 doses was not administered: On hold loose bm. BMR; none 8/24/20, MAR- one large loose bm. R1's physician visit note dated 8/24/20, included the recapitulation from the hospital visit that directed to continue the lactulose with a goal of having 2-3 bowel movements per day. The note also included, "Lactulose doses have been held on a couple of occasions on review of the MAR. Writing orders today to administer to aim to achieve 2-3 bowel movements per day. 8/25/20, MAR - 1 of 3 doses not administered: due to condition. BMR; none 8/27/20, BMR - none, 8/28/20, BMR; one small bm. 8/29/20, MAR - 1 of 3 doses not administered: due to condition. BMR; none 8/30/20, MAR - 2 of 3 doses not administered; drug/item unavailable. 9/13/20, MAR - 1 of 3 doses not administered; On hold for loose stools. BMR; one large soft bm. 9/14/20, BMR; one medium soft formed bm 9/15/20, MAR - 1 of 3 doses not administered; drug item unavailable. BMR; none 9/27/20, MAR - 2 of 3 doses not administered;	F 760		

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F 760	Continued From page 93 drug item unavailable. BMR; one large bowel movement. 10/14/20, MAR- 1 of 3 doses not administered; resident refused. BMR; none 10 /15/20, MAR- 1 of 3 doses not administered; resident refused. BMR; one medium soft formed 10/17/20, MAR- 1 of 3 doses not administered; resident refused. BMR; no documentation. R1's record and facility information was reviewed and found medication errors were not completed for the omitted Lactulose, and lacked evidence the physician had been notified. During an interview on 10/21/20, at 2:35 p.m. the pharmacy technician (PT) stated medications were delivered to the facility, if there was a medication not available then staff would just give when the medication was available. PT confirmed pharmacy delivery services were available 24/7, however facility staff would have to communicate they wanted the medication immediately. PT stated if the pharmacy did not have the medication, facility staff should notify the physician; omission of medication was considered medication error. During an interview on 10/21/20, at 2:39 p.m. the pharmacist (PH) stated lactulose was ordered for encephalopathy; resident had liver issues. PH indicated when someone has liver issues the body accumulates ammonia. If the medication isn't administered appropriately, or not enough bowel movements it could cause ammonia levels to rise and cause further liver damage. PH stated mild symptoms would include confusion and delirium, and more severe symptoms included seizures and maybe some cardiac pulmonary issues.	F 760		

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F 760	Continued From page 94 During an interview on 10/21/20, at 3:02 p.m. registered nurse (RN)-C was asked why R1 received lactulose, RN responded "for constipation". RN-C reviewed R1's medication orders and confirmed the diagnoses associated with the medication was "constipation" and not hepatic encephalopathy. RN-C stated it was not his job to ensure the correct indications for medications. RN stated the medication had been held for loose stools and shouldn't have been based on the wrong indication. During an interview on 10/22/20, at 9:34 a.m. licensed practical nurse (LPN)-A stated if the medication was not administered it was considered a medication error. LPN-A indicated if the medication was not available then the TMA needed to communicate to the nurse. LPN-A stated medications could not be held unless there was an evaluation by licensed nurse. During an interview on 10/25/20, at 8:30 a.m. director of nursing (DON) stated if a medication is not available the provider needed to be notified; it would be a medication error if it was not administered when it was supposed to be. DON indicated the indication for the lactulose should not have been constipation, and not held for loose stools. During an interview on 10/29/20, at 3:30 nurse practitioner (NP)-B indicated an awareness the medication was being held for loose stools, and though the issue had been resolved. NP-B was not aware the medication was not administered related to availability. NP-B stated she would expect nursing to notify her for a change if	F 760		

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F 760	Continued From page 95 needed. Facility policy Administering Medications 2/2019, included; To administer resident medications in a safe and accurate manner that will ensure the 6 rights of medication administration. Medications are administered in accordance with the orders. Medications are administered within their prescribed time. The person preparing or administering the medication will contact the provider if there are questions or concerns regarding medication. Obtain vital as ordered with medication administration prior to administering the medications. Sing medication out in the electronic record/MAR at time of medication administration. Any refused medication is destroyed and documented as a refusal (did not instruct to re-attempt).If medication error is noted refer to Medication Error policy.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		12/4/20

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F 761	Continued From page 96 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure medication was not expired and had the appropriate label in 1 of 1 medication carts. Findings include: During an observation on 10/21/2020, at 5:22 p.m. registered nurse (RN)-B stated that the facility had epinephrine in the medication cart. RN-B unlocked the cart and opened the drawer; a box that contained two epinephrine 0.3-milligram injection pens was observed. RN-B stated according to the date on the box the pens expired March 2020, RN-B also stated the box did not have a pharmacy label on the box. RN-B indicated he was not aware of where the pens had come from. RN-C also observed the box, confirmed the medication had expired in March and that the box did not have a label. RN-C stated if we needed epinephrine, it was in the emergency kit. Both RN's stated the medication should have been removed from the cart and disposed of.	F 761	N/A All residents with orders for Epipens have the potential to be affected. Alixa Pharmacy "Medication Labels" policy reviewed and remains current. All licensed staff and TMAs will be educated on Medication Labels policy at the nursing staff trainings on 12/1 and 12/2. Medication Carts will be audited for expiration dates 1x/week for 4 weeks. Administrator/Designee is responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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F 761	Continued From page 97 During an interview on 10/22/2020, at 8:00 a.m. director of nursing (DON) stated the medication should have not been in the cart without the appropriate medication label and stated medications that were expired should have been removed from the cart and returned to pharmacy or wasted. A facility policy was requested and not received.	F 761		
F 806 SS=J	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food items were served in a manner to accommodate known allergen for 1 of 1 residents (R5) who had a known allergy to peanuts, and history of anaphylactic reaction (a severe, potentially life threatening allergic reaction) to peanuts. This resulted in an immediate jeopardy (IJ) situation for R5 when he was served food items which contained peanuts. The IJ began on 10/5/20, when R5, with a known allergy to nuts was served a dessert containing	F 806	R5's allergies and care plan have been reviewed and remains current. All residents with food allergies residing at Madonna Towers of Rochester have the potential to be affected. Meal Tray Identification policy has been reviewed and remains current. All resident diet tray cards, as part of the abatement plan have been reviewed for resident food allergy information per electronic health record data to verify for	12/4/20

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F 806	Continued From page 98 peanut butter. Dietary staff served a different dessert than what R5 ordered from the dietary card which listed an allergy to nuts. The administrator and director of nursing (DON) were informed of the IJ on 10/21/20 at 6:45 p.m. The facility implemented corrective action and the IJ was removed on 10/22/20 at 6:00 p.m. However, non-compliance remained at the lower scope and severity of D, isolated, no actual harm, with potential for more than minimal harm that is not immediate jeopardy. Findings include: R5's Face Sheet included diagnoses of a stroke, heart disease and dementia. R5's quarterly Minimum Data Set (MDS) assessment dated 9/17/20, indicated R5 had adequate hearing and speech, understood and was able to comprehend. R5 refused to answer questions for the brief interview for mental status (BIMS) and had no signs and symptoms of delirium. R5 was independent with bed mobility, walking, dressing and toileting. R5's care plan for nutritional status dated 10/22/18, identified an allergy to nuts, specifically peanuts and cashews. During an interview on 10/20/20, at 9:06 a.m. R5 stated he recently received a dessert containing peanut butter and stated he was allergic to peanuts. R5 stated after taking a small bite, he'd recognized the peanut taste and spit it out. R5 stated he had a "light asthma attack," adding "two hours went by and I was bent out of shape. I could have died and damn right I was scared."	F 806	accuracy. As part of the abatement plan, resident diet cards had a red dot added to bring attention to a food allergy. As part of the abatement plan, culinary staff were educated on Meal Tray Identification policy and using and following diet cards and again at staff meetings on 12/1 and 12/2. Culinary staff will have daily pre-meal service huddles at lunch and dinner meals to review resident diet changes with all culinary staff. A communication book will also identify changes for staff. Food items that contain known resident food allergens will be labeled so serving staff will be informed to avoid serving these items and alternate options provided. Diet cards and labeled food will be audited 3x/week for 4 weeks for diet accuracy and food allergens. Administrator/Designee is responsible for compliance. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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F 806	Continued From page 99	F 806		

R5 stated he didn't go to the hospital this time but added, "it took a good two days to get it out of my system."

Review of R5's progress note dated 10/5/20, at 6:07 p.m. registered nurse (RN)-B documented R5 was anxious and agitated because he had a bite of a peanut which he was allergic to. R5 reported to RN-B he swallowed a small amount and when he tasted the peanut, he spit most of it out. At 7:04 p.m. RN-B contacted a provider and received an order for epinephrine injectable to be given only if R5 was symptomatic. R5 had no symptoms of shortness of breath, rash or gastrointestinal symptoms. R5 was monitored closely and did not develop signs or symptoms of an allergic reaction and did not require epinephrine.

A prior incident from 9/28/19 at 6:40 p.m., was documented in the record indicating the severity of R5's reaction to nuts. The documentation included: "Rt [resident] reported that he had ingested the dessert that had peanut butter in it. Rt. has a documented allergy to nuts. Rt. stated he had a small bite. Rt reported an upset stomach. Rt. unable to state symptoms of last allergic reaction but when asked if his mouth or tongue swelled up he responded, 'yes'. Rt. remained A x O x 4 (alert and oriented times 4) and was able to answer all questions clearly. No rash, difficulty breathing, itching or mouth swelling noted. VS WNL (vital signs within normal limit) see chart. On call for [doctor name], [doctor name] notified and gave orders to send pt. to ER via [ambulance name] emergently. Pt's contact [name], notified. Report called to [name of hospital] ER."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245153	A. BUILDING _____ B. WING _____	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER INC	4001 19TH AVENUE NORTHWEST ROCHESTER, MN 55901

(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 806	Continued From page 100 During an interview on 10/21/20, at 9:48 a.m. cook (C)-C stated all food is made in the main kitchen and then delivered to the kitchen at the nursing home, referred to it as "nursing care kitchen." C-C stated some foods came from the main kitchen with nuts in them and it was up to the server to make sure R5 did not receive them. C-C stated R5 had requested a butterscotch bar for dinner on 10/5/20, but received a scotch-a-roo bar which contained peanut butter. C-C did not know how this occurred. During an interview on 10/21/20, at 9:53 a.m. culinary services director (CSD)-A stated residents were given a paper menu at breakfast to fill out for the next day. For residents with food allergies, their menus were customized to include their allergies; CSD-A verified R5's menu listed his allergy to peanuts. CSD-A was aware of the incident on 10/5/20, when R5 received a dessert containing peanuts (a scotch-a-roo bar). CSD-A verified "R5 ordered the proper product, but we sent the wrong one." In addition, CSD-A stated on 10/17/20, R5 requested an oatmeal cookie on his menu, but a Monster cookie containing peanuts was placed on his tray. The error was discovered in the nursing care kitchen and R5 did not receive the cookie containing peanuts. CSD-A verified there was nothing in place for culinary staff to know specific ingredients in food items to ensure a resident does not receive food for which they were allergic. When asked if an incident report had been completed when R5 received food for which he was allergic, CSD-A stated it would be a grievance filed by the social worker (SW). When asked how the SW would learn about this incident, CSD-A stated he didn't	F 806		

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F 806	Continued From page 101	F 806		

know.

During an interview on 10/21/20, at 11:03 a.m. SW-A stated she heard about R5 receiving the scotch-a-roo bar made with peanut butter at a leader meeting. SW-A stated it was up to the person who discovered the event to fill out an incident report, adding "in this case, it was nursing."

During an interview on 10/21/20, at 11:09 a.m. the director of nursing (DON) stated she was not aware R5 received a dessert which contained peanuts on 10/5/20. The DON stated the nurse on duty that evening RN-B, was an agency nurse and added, "I'm surprised I wasn't notified." The DON stated she would follow up with RN-B.

During an interview on 10/21/20, at 6:35 p.m. lead cook (LC)-B stated all food was made in the main kitchen of the facility and delivered in metal containers to nursing care for distribution. LC-B provided a document displaying the menu for "fall week 1, Thursday" which indicated the quantities of food items to send to nursing care. While the document did not indicate ingredients for any food items, LC-B stated nursing care was responsible for determining resident allergies.

On 10/21/20, at 6:45 p.m. dietary aide (DA)-A stood in the kitchen at the steam table, as he placed the entrees onto individual plates and handed the plate to an aide who set the plate on a tray and added cold food, beverages and dessert items to each tray. DA-A stated pans of food were delivered to the nursing care kitchen from the main kitchen in steel containers and put in steam wells. DA-A stated desserts arrived

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F 806	Continued From page 102	F 806		

plated with plastic over the top, in a tall enclosed cart on wheels. DA-A stated staff looked at the individual resident's paper menu and diet card in order to plate the food accurately. Resident diet cards included name, room number, allergies, likes, dislikes and food preferences. DA-A verified R5's diet card indicated an allergy to nuts: cashews and peanuts.

DA-A stated he was working the evening of 10/5/20, when R5 received the scotch-a-roo bar. DA-A was unaware the kitchen brought over scotch-a-roo bars and stated he thought the bars looked like butterscotch bars. DA-A stated staff went by the menu to determine the food being served and on 10/5/20, there was no indication they were serving scotch-a-roo bars.

During an interview with dietary staff on 10/21/20, at approximately 6:55 p.m., dietary aides (DA)-B, (DA)-C and (DA)-D, indicated they did not know there were nuts or peanut butter in scotch-a-roo bars. In addition, they were not able to articulate the difference in appearance between butterscotch bars and scotch-a-roo bars. The dietary aides verified no one had talked with them following the incident on 10/5/20. They further stated there were no changes made to prevent it from occurring again, nor did they receive new training. DA-B stated they talked among themselves that night and just decided they needed to be more careful.

During an interview on 10/22/20, at 12:51 p.m. CSD-A stated after the first incident with R5 she "told staff not to change the menu on their own." CSD-A went on to say there was only one dessert that day and it was supposed to be

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F 806	Continued From page 103	F 806		

butterscotch bars, but it was changed to scotch-a-roo bars. CSD-A verified scotch-a-roo bars were periodically served to residents in nursing care and when asked how staff would know they contained peanut butter, he verified "they wouldn't."

The facility policy titled Meal Tray Identification, dated 2012 indicated:
A tray card (or approved alternative) is provided for each resident receiving meals from the culinary services department, to ensure that meal conforms to physician diet order and that likes, dislikes and individual special needs of the resident are being met.
The culinary services director is responsible for providing an accurate tray card for each resident, with diet conforming to physician order, and which contains the following minimum information, updated as needed:
--Name (first and last)
--Room number
--Diet exactly as physician ordered
--Beverage preference
--Food preferences
--Known food allergies
--Special needs (e.g., adaptive devices, salt substitute)
The tray card will remain with the corresponding tray throughout the meal service."

The immediate jeopardy that began on 10/5/20, was removed on 10/22/20, at 6:00 p.m. when it could be verified through observation the facility had implemented a new process to ensure residents were not served food for which they were allergic. Staff were observed to conduct a pre-meal service huddle to review resident diet

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F 806	Continued From page 104 changes, a red dot was added to diet cards to bring attention to food allergies. Review of diet cards and food menus were followed by staff to ensure adherence to resident food allergies and preferences. During meal service, food items which contained known resident allergens were labeled in order for staff to avoid serving them. In addition, the facility conducted a verification of food allergies on diet cards against food allergies identified in the resident's electronic medical record. Staff education on the meal tray identification policy, including utilization of diet cards, began on 10/22/20, continuing for staff to be conducted prior to the next scheduled shift staff worked. A communication book for staff had been established to identify resident diet changes. Lastly, an audit was conducted by the culinary manager or designee, of diet cards to verify they were accurately labeled for diet accuracy and food allergens. Audit results were reported to the quality council.	F 806		

Electronically delivered
November 17, 2020

Administrator
Madonna Towers Of Rochester Inc
4001 19th Avenue Northwest
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: 243111

Dear Administrator:

The above facility was surveyed on October 19, 2020 through October 23, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 64970
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
	00419	A. BUILDING: _____ B. WING _____	C 10/23/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On dates 10/19/2020 through 10/25/2020, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H5153039C, with deficiencies cited. H5153040C, with a deficiency cited H5153041C, with deficiencies cited H5153044C, with deficiencies cited The following complaints were NOT substantiated H5153042C H5153045C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure sufficient staff to provide and meet the assessed needs for 4 of 4 residents (R11, R12, R13, R14) who voiced concern with lack of sufficient staffing in the facility. The lack of	2 800	Corrected	12/4/20

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2 800	Continued From page 2 sufficient staff had the potential to affect all 50 residents who resided in the facility. Findings include: R12 R12's facesheet, printed 10/23/20, indicated diagnoses of Parkinson's disease (disease affecting movement), age-related physical debility, osteoporosis (a condition in which bones become weak and brittle), muscle weakness and repeated falls. R12's quarterly Minimum Data Set (MDS) assessment dated 8/18/20, indicated R12 was cognitively intact, had adequate hearing, impaired vision requiring corrective lenses, clear speech, was understood and had clear comprehension. R12 required extensive assistance of two staff for bed mobility, transfers and toileting, and extensive assistance of one for dressing, walking in her room and locomotion on the off the unit. R12's care plan goal dated 9/3/20, indicated R12 would reach maximum rehabilitation potential and improve ability to perform activities of daily living (ADL's) for bathing, grooming, dressing, oral care. The care plan indicated R12 needed assistance with evening cares, toileting, incontinence care and ambulation. Staff responsible for these activities were identified as nursing assistants and nurses. During an interview on 10/19/20, at 10:58 a.m. R12 stated there was "not enough staff." R12 stated staff cannot always come when she puts her call light on and stated, "Nothing makes you feel more helpless at night when it's dark and no	2 800		

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2 800	Continued From page 3 one comes." R12 stated, "Staff can't come right away because they can't leave the person they're working with." R12 stated, "They always put you on the toilet and say I'll be right back, but they aren't right back." R12 stated, "I'll be right back are their famous words." R12 stated, "I start out using my walker to get to the bathroom, but my kids say don't do that, I might fall." During an interview on 10/22/20, at 1:31 p.m. R12 stated, "If they walk me once a week, I'm doing good, and I do need it. I am getting weaker every day and I am not going to last long at this rate. I'm not active enough." R12 stated she would like to walk in the hallway. R12 stated that in the morning, she would ask staff if she could walk and staff say, "Later, but later never comes." R13 R13's face sheet, printed on 10/23/30, indicated diagnoses of ataxia (impaired balance or coordination), degeneration of nervous system (loss of function or structure of nerves of the spinal cord). R13's quarterly Minimum Data Set (MDS) assessment dated 9/29/20, indicated R13 was cognitively intact, had adequate hearing and vision, clear speech, was understood and had clear comprehension. R13 required extensive assistance of one staff for bed mobility, transfers and toileting, locomotion on and off the unit, and walking in room or corridor occurred only once or twice. R13's care plan goal dated 7/13/20, indicated R13 would continue to participate in activities of daily living (ADL's) while able. R13's care plan indicated R13 required assistance for bathing,	2 800		

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2 800	Continued From page 4 brushing teeth, grooming, dressing, toileting, incontinence care and ambulation. Staff responsible for these activities were identified as nursing assistants and nurses. During an interview on 10/19/20, at 2:09 p.m. R13 stated in the last 6 months, the facility had lost a lot of staff and staff morale was low. R13 stated, "I look at three things in order to rate staff: personality, efficiency and timeliness." R13 stated, "Most of the pool staff don't have any, don't treat us with respect and are not personable." R13 stated, "With pool staff, I wait a long time." R13 stated, "I used to wait 10 minutes and today I waited 40 minutes." R13 stated, "They are short staffed." R13 stated, "Management pushes them. A lot of staff are working double shifts." R13 stated, "I hate seeing good staff leave and just poor ones stay." R13 stated, "Personally, I have not suffered any consequences to having to wait for a call light to be answered...yet." During an interview on 10/22/20, at 12:45 p.m. R13 stated they used to have two bath aides and now have only one. R13 stated this change negatively impacted her, adding when her nursing assistant (NA) had to give an evening bath, "she can't help me and apologizes she is not able to get to me sooner." R13 stated they used to have a restorative aid and was able to use the bicycle and walk in the hall, but now that they are short staffed, she doesn't walk. R13 stated the new management was more concerned about the bottom line than the residents. R13 stated, "I'm paying a lot of money to be here and they aren't always meeting my needs."	2 800		

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2 800	Continued From page 5 R11 R11's facesheet, printed 10/23/20, indicated diagnosis of dementia, age related physical debility, osteoarthritis and muscle weakness. R11's quarterly Minimum Data Set (MDS) assessment dated 8/11/20, indicated R11 had moderate cognitive impairment, had adequate hearing and vision, clear speech, was understood and had clear comprehension. R11 required extensive assistance of one staff for bed mobility, transfers and toileting and locomotion on and off the unit. R11 required limited assistance of one when walking in room, and walking in the corridor with assistance of one staff occurred only once or twice. R11's care plan goal dated 8/19/20, indicated R11 maintain current level of functional mobility with activities of daily living (ADL's). R11's care plan indicated R11 required assistance putting on compression stockings, bathing, oral care, grooming, dressing, toileting, incontinence care and ambulation. Staff responsible for these activities were identified as nursing assistants and nurses. During an interview on 10/22/20, at 1:52 p.m. R11 stated she wanted to walk, "but staff don't have time." R11 stated, "I'm losing strength." R11 stated she could not recall the last time staff helped her walk. During a telephone interview on 10/22/20, at 2:05 p.m. family member (FM)-E stated R11 wasn't doing very well. FM-E stated R1 had accidents (soiled herself) quite a bit, and that upset her. FM-E stated, "To get them to find the time to help her...they're understaffed like everyone else and	2 800		

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2 800	Continued From page 6 they don't have time." FM-E stated, "I've had to call the facility to ask them to help toilet her and it just falls on deaf ears." FM-E stated, "They're overwhelmed and sympathetic, but I don't know what's happening." R14 R14's facesheet printed 10/23/20, indicated diagnoses of osteoarthritis (wearing down of bones), kyphosis (forward rounding of the back), obesity and muscle weakness. R14's quarterly Minimum Data Set (MDS) assessment dated 10/6/20, indicated R14 was cognitively intact, had adequate hearing, impaired vision requiring corrective lenses, clear speech, was understood and had clear comprehension. R14 required extensive assistance of one staff for bed mobility, transfers, dressing and toileting. R14 required limited assistance of one when walking in room, and limited assistance of one with locomotion on the unit. R14 care plan goal dated 10/15/20, indicated R14 would continue to participate in activities of daily living (ADL's) as able. R14's care plan indicated R14 required assistance with putting on and taking off compression stockings, bathing, oral care, dressing, grooming, toileting, incontinence care and ambulation. Staff responsible for these activities were identified as nursing assistants and nurses. During an interview on 10/19/20, at 1:13 p.m. R14 stated there "absolutely was not" enough staff to meet her care needs. R14 stated, "I can have my light on and I've had to wait as long as	2 800		

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2 800	Continued From page 7 30 minutes." R14 stated, "I take prune juice, when I have to go I have to go, so I try and go by myself." R 14 stated, "I'm having to do things on my own that I'm not supposed to do." R14 stated, "This hallway doesn't have enough help and hasn't for most of the year I've been here; it's gone downhill terribly." R14 stated, "Staff is leaving; they don't like the amount of work they have to do and don't like mandated overtime." R14 stated when long call lights and staffing were brought up at resident council, "It got a bit heated and the administrator backed away from it and changed the subject, he didn't want to talk about it." R14 stated, "It was evident we weren't allowed to say much as he cut us off." R14 stated, "They say it's supposed to be our home, but it's far from it." R14 stated, "Feels like a war between the workers and whoever is running the show." R14 stated she heard this used to be a five star place but now it was considered only two stars. During an interview on 10/19/20, at 10:29 a.m. nursing assistant (NA)-A stated, "There is not enough staff." NA-A stated staff starting leaving when the new administrator came because more work was added without enough staff. NA-A stated there used to be two bath aids for 60 residents, but one bath aid was taken away. NA-A stated random aids are now assigned to assist with baths on evening and weekends and this means there are less nursing assistants on the floor to assist residents and answer call lights. During an interview on 10/19/20, at 2:21 p.m. trained medication aid (TMA)-A stated, "Staffing is different lately but nothing anyone can control" and that leadership was trying. TMA-A stated a	2 800		

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2 800	Continued From page 8	2 800		

few people have left and no one was applying for positions, adding there were a lot of pool staff, more than usual. TMA-A stated new staff were younger and the job was not what they expected. TMA-A stated, "It's easy to become a nursing assistant, but when they get into it, it's more than they bargained for." TMA-A stated there were a lot of open positions and a lot of chaos going on right now. TMA-A stated they were working short two nursing assistants this day. When asked what might not get done due to working short, TMA-A stated, "probably not get to residents very fast when they put their call lights on."

During an interview on 10/19/20, at 2:57 p.m. registered nurse (RN)-C stated at times that there was not enough staff. RN-C stated as the charge nurse, if the unit was not fully staffed with nursing assistants, he chipped in and helped them. RN-C added that made it challenging to get his work done, such as wound care, supervising the work of the nursing assistants and acting as a resource to them. RN-C felt they provided safe care, but added short staffing leads to burnout and staff turnover.

During an interview on 10/20/20, at 9:42 a.m. (RN)-A stated most days they had enough staff. RN-A stated "it seems like it's been random lately." RN-A stated, "For nursing, it's been okay, but the nursing assistants are short." RN-A stated that sometimes the facility mandated a nursing assistant to stay longer or called staff in from home. RN-A stated for example, "the night shift nursing assistants have already worked 12 hours, so if they work more, it would be 16 hours." RN-A stated the DON wanted to hire agency staff and regular staff, but neither were available. RN-A stated when they are short

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2 800	Continued From page 9 nursing assistants she tried to help them with their work. During an interview on 10/20/20, at 11:30 a.m. the director of nursing (DON) acknowledged they can't find staff to fill positions. DON stated she received push back at the suggestion of not taking new admissions in order to decrease census for the staff they have. Even with the use of agency staff, DON stated they are not adequately staffed, yet had not seen negative outcomes such as falls, pressure ulcers or increase in incontinence. DON added they had seen an increase in self-transfers, but without an increase of associated falls. DON stated she felt it was like a ticking time bomb, stating something would eventually happen to a resident. According to the DON, there were daily meetings with human resources but stated "We aren't getting applicants and our current staff is burned out." DON stated they were down two nurse managers, so the nurse supervisor got assigned to resident care and the DON filled both the supervisor role and the DON role. DON stated, "Staffing was taking all the focus, so nothing else is getting done." DON stated, "Staff just get done what they have to do that day; nothing is being improved." DON stated, "They can't provide the care residents deserve." During an interview on 10/20/20, at 4:45 p.m. (NA)-B stated she usually worked without taking a break as there was too much work to get done. NA-B stated there were only "three long-timers left" and staff were quitting due to working conditions. NA-B stated they no longer got overtime after eight hours, so lost incentive to work extra, although she did sometimes. NA-B stated there were only two aids to care for 30	2 800		

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2 800	Continued From page 10 residents, stating she had 15 residents by herself that morning. NA-B stated things that don't get gone due to lack of staff included dirty laundry, call lights, turning, walking, and toileting. NA-B stated, "I've seen lights be on for an hour. It's stressful...I go home thinking about all the things I couldn't do." During an interview on 10/21/20, at 8:42 a.m. (NA)-C stated staffing had been frustrating. NA-C stated, "We hire new staff, train them, and then they leave." NA-C stated, "Agency staff is on the schedule, but don't show up at the last minute." When asked what she was not able to do when pressed for time, NA-C stated, "Checking on my residents." NA-C stated she had not been able to walk residents who are on restorative programs and stated, "Something has to give, and we can't do it all." NA-C stated she had brought this to the attention of the DON and the DON stated they were working on hiring more staff. NA-C stated they used to have a restorative aide, but that position was eliminated and now all NA's are expected to do it along with their other responsibilities. NA-C stated, "It's almost impossible to walk residents too, there isn't time." During an interview on 10/21/20, at 4:30 p.m. human resources manager (HR)-D stated it was hard to fill nursing assistant positions even with substantial monetary bonuses for full time positions and for internal referral bonuses. HR-D stated they used to have an employee referral base, but current staff no longer tell friends and family about open positions, "they don't want them to come here and work short." HR-D stated they got applicants, but not qualified applicants. HR-D stated, "We get applications from nursing assistants who have worked at every long term	2 800		

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2 800	Continued From page 11	2 800		

care facility in town in the last three years, and we are the only place they haven't worked. That's a red flag." HR-D stated it was difficult competing with the local hospital. During the same interview, finance manager (FM-C) stated they were using a lot of agency staff, but workers do not show up. FM-C stated staffing was discussed at leadership huddle daily, they talk about who was being hired, who had resigned, where new hires were in orientation. FM-C stated as a corporation, they offer reimbursement tuition, loan forgiveness and bonuses. FM-C stated, "Corporate changed from an 8/80 work week to a 40 hour work week in July and "some staff lost incentive to pick up shifts." FM-C stated they were looking at ways to speed up the hiring process and ways to increase wages. FM-C stated, "Other nursing homes are in the same boat, it's an overbuilt market, too many beds and we are fighting for the same people." FM-C stated it was difficult to compete with local Best Buy and Hobby Lobby wages. FM-C stated they were considering putting individuals through a nursing assistant course, paying for the course and giving them a full time position.

During an interview on 10/22/20, at 11:07 a.m. corporate vice president of operations (VPO)-G stated, "In this industry, we are all staffing challenged, we are trying to ensure we have staff to meet the needs of our residents." VPO-G stated there was a culture issue at this facility and "It's unfortunate where it's been allowed to go." VPO-G stated not being able to meet resident needs was a combination of short staffing and how existing staff were working, stating "leadership needed to be on the floor and providing guidance." The administrator stated that a lot had happened at the facility with

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2 800	Continued From page 12 Covid19, changes in leadership, staff quitting, and trying to rebuild. The administrator stated, "We staff some pretty good ratios" and resident care concerns were more related to staff inefficiencies. Facility policy titled Staffing and Daily Work Assignments dated 2018, indicated: Purpose: to ensure staff provide cares in accordance with resident needs. Policy: Sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. All nursing service personnel shall follow daily work assignment and perform assigned duties in accordance with professional standards of practice. Procedure: 1. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents basked on each residents plan of care. 2. Inquires and concerns relative to staffing should be directed to the administrator/designee. 3. Certified nursing assistants (CNAs) and trainees carry out their daily assignment in a profession manner and in accordance with established nursing procedures and protocols. Facility Assessment, dated 10/28/19, indicated: 1. Person-centered service and care offered based upon needs of those we serve. This included Quality of Care: ADL support, mobility assistance, bowel and bladder care and toileting support, and rehabilitation therapy. 2. Staffing is planned in advance and altered based upon census in all departments. In addition, staffing in nursing are altered based	2 800		

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2 800	Continued From page 13 upon resident need and the number of admission and discharges. SUGGESTED METHOD OF CORRECTION: The facility administrator or DON could review and revise policies and staffing schedules to assure adequate staff are available to assist residents in a timely manner and to meet all resident needs. A designated staff could monitor the system to assure cares are being delivered and residents are supported to achieve and maintain their highest practicable physical, mental, and psychosocial well-being. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a 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 interview and document review, the facility failed to monitor and assess for change of	2 830	Corrected	12/4/20

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2 830	Continued From page 14 condition, and failed to follow physician orders, for 1 of 1 resident (R2) who had a history of blood clots in both legs and respiratory concerns with a potential for pulmonary emboli (PE, clots in the lungs). As a result of the facility's failures, an immediate jeopardy (IJ) situation was identified for R2 who had displayed respiratory distress with significantly low oxygen (O2) saturations, requiring an increase in oxygen and emergent transfer to the hospital emergency room (ER). The immediate jeopardy began on 9/25/20, when the facility did not send R2 to the ER per orders and was identified on 10/21/20. The administrator, director of nursing (DON), licensed social worker (LSW), culinary director, and infection preventionist were notified of the immediate jeopardy at 12:45 p.m. on 10/21/20. The immediate jeopardy was removed on 10/22/20 at 5:45 p.m., but noncompliance remained at the lower scope and severity level of G - isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy. In addition, the facility failed to manage, monitor, assess for the use of bowel medications to prevent constipation for 1 of 1 residents (R8), who had a diagnosis of constipation and was on hospice for end of life care; and failed to monitor and evaluate signs and symptoms of fluid overload and follow physician orders for 1 of 2 residents (R9) with a diagnosis of stage 3 (moderate) chronic kidney disease. Findings include: R2's admission Minimum Data Set (MDS) assessment dated 9/6/2020, indicated R2 had moderate cognitive impairment and required extensive assistance from two or more staff for bed mobility and transfers and required extensive assistance from one staff for toileting, hygiene,	2 830		

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2 830	Continued From page 15 and dressing. The MDS indicated R2 had not required oxygen, was administered anticoagulant medications, and had a surgical wound. R2's Face Sheet, included diagnoses of acute embolism, deep veing thrombosis (DVT) of right lower extremity (added 9/14/2020), and atelectasis (lung collapse) (added 9/1/2020). R2's Physician standing orders included the following: Initiate and titrate supplemental 02 at 1-4 l/min (liters per minute) via nasal cannula PRN (as needed) for dyspnea (shortness of breath), hypoxia (02 saturation <90%); and to update provider with nursing assessment. R2's care plan dated 9/11/2020, indicated R2 experienced hypertension. Interventions were identified to include administer medications as ordered, check blood pressure per order, and observe for signs of high blood pressure including; dizziness, chest pain, dyspnea. The care plan did not address the instructions as outlined in Required Follow Up section of the hospital Discharge Summary to monitor for deep vein thrombosis (A condition in which the blood clots form in veins located deep inside the body) and PE (pulmonary embolism-A condition in which a blood vessel in the lung(s) gets blocked by a blood clot). R2's hospital Discharge Summary Brief Overview dated 9/14/2020, had a section called, Active Issues Requiring Follow-up. This section included, Continue close monitoring of the right lower extremity for propagation/worsening of swelling, evidence of neurovascular compromise (diminished pulse, numbness/tingling, new/worsening pain in the distal extremity, weakness) and any evidence of shortness of breath, chest pain, and/or hypoxemia that may suggest evidence of possibility of pulmonary embolism. Please wrap lower extremity with low	2 830		

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2 830	Continued From page 16 stretch wraps daily for swelling control symptoms as tolerated by patient." R2's progress note dated 9/14/2020, at 10:36 p.m. included, "02 84 when lying. O2 started at 1 lit [liter] per minute. Call light within reach. Will continue to monitor." The note also indicated a skin assessment was completed; purple blueish coloration of right lower leg, edema +1. Scar from surgery 5 centimeters long. R2's physician visit dated 9/15/2020, included recapitulation of hospital admission and discharge orders for active surveillance of the right lower extremity, monitoring for signs/symptoms of pulmonary embolism, worsening DVT, and oxygen requirements. The note indicated nursing reported increased oxygen need when working with physical therapy, and physical therapy requested order to increase oxygen for therapy sessions. Resident denied shortness of breath, chest pain, numbness and tingling in the extremity. The note indicate the physician would consult with vascular clinic for increasing oxygen. Physical exam, skin: Purple bluish coloration of right lower leg. Edema +1 right leg. The note included orders for ultra sounds and "3. Nursing will continue close monitoring of right lower extremity for swelling, diminished/loss of pulse, numbness/tingling, new/worsening pain in the distal extremity, weakness, shortness of breath, chest pain, and/or hypoxemia that may suggest possibility of pulmonary embolism." R2's progress note dated 9/15/2020, at 4:21 p.m. indicated a telephone order was obtained from the NP (nurse practitioner); oxygen needs to be increased to 3 lpm to keep Sp02 above 90%. "Resident noted to de-sat with exertion." A subsequent note at 9:49 p.m. included the ultra sound results; "No DVT is seen in bilateral lower	2 830		

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2 830	Continued From page 17 extremities." R2's progress note dated 9/16/2020, at 2:01 p.m. "PT [physical therapist] found pt [patient] sleeping in w/c [wheelchair] and didn't touch her lunch, refusing it. Pt on room air and O2 SATS 95%. sit to stand CGA [contact guard assist] .... Pt stood for 1 min [minute] w/ PT limiting time to assess O2 and initially 92% upon sitting and then decreased to 73% and took about 1 min to rebound. PT donned O2 at 1 lpm and O2 93%. Stood 2nd time and able to place oximeter on finger and decreased to 66% after about 45 sec [seconds] of standing and had pt immediately sit down. Vital machine then had dead battery and cord retrieved to plug in and by the time this took place O2 at 78% and then quickly returned to >90%. O2 increased to 3 lpm and pt stood 3rd time and watched O2 and decreased to 78% at 20 sec and had pt stop. Pt took 1 min 20 sec to recover. Reassessed O2 SATS to do quick wean back to room air and at [sic] was in 80's and quickly above >90. Monitored to 2 lpm, 1 lpm and to room air w/ pt at 100% by end. Notified nurse of pt desaturation w/ activity as nurse arrived to give meds." R2's progress note dated 9/17/2020, at 11:39 a.m.stood with PT for 1 minute, and PT would not let patient stand longer to ass O2 sats/tolerance. Donned oximeter after standing and O2>90% entire stand. After sitting, O2 eventually dropped to 81% after sitting for awhile and with therapeutic rest at 100%. Pt stood 2nd time and 15 seconds only as O2 dripped to 85% quickly and made pt sit down with O2 dropping to 74% with about 1 mine to recover. Discontinued standing attempts at this time. R2's progress note dated 9/18/2020, at 11:13 a.m. indicated R2 denied feeling any shortness of breath and did not display symptoms when laying	2 830		

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2 830	Continued From page 18 down. A subsequent note at 1:13 p.m. included, "PT just completed the following concerning tx [treatment]: Pt found asleep in w/c w/ lunch tray, on room air. O2 SATS 84% on R [right] hand and compared to L [left] hand at 80%. PT donned O2 on 3 lpm to increase O2 SATSs for mobility and increased to 95%. Pt stood CGA w/ FWW [front wheeled walker] and decreased to 69% after just 25 sec of standing and had pt sit back down. Pt took 2 1/2 min to recover >90%. PT was not going to stand pt again, however, pt requesting to use toilet urgently and instructed pt on need to transfer quickly to keep O2 SATS up. PT had pt rest prior to toilet transfer CGA and O2 decreased to 49% on 3 lpm. PT immediately notified nsg [nursing]. Nurse arrived while pt on toilet and updated and nurse stayed present for toilet>w/c transfer w/ CGA and dependent upon changing and cleaning. O2 SATS then decreased to 39% with O2 on 3 lpm and took 5 1/2 min to recover >90%. Nurse to update NP and rest of tx withheld. At rest in w/c observed O2 SATS in mid 60's to 100% while PT documenting" R2's clinic registered nurse telephone encounter note dated 9/18/2020, at 1:23 p.m. included, "Call received from nurse [name of nurse] at Madonna Towers, Resident was in PT [physical therapy] when resident's 02 saturation was checked. Room air sats were 95%. Nurse states that resident's 02 sats were going as low as 50% with oxygen 3L on, even at rest. Resident appears in no apparent distress. No shortness of breath or cyanosis (bluish discoloration) noted. Writer asked for accuracy of unit used to test. She states they compared with another machine and were getting the same kind of readings. She states readings were "all over the place" at standing and sitting positions. Writer requested an S-bar be sent with updated vitals. Resident	2 830		

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2 830	Continued From page 19 remains on 3L of 02. R2's follow-up physician's note dated 9/18/2020, at 1:43 p.m. included "Called facility and talked to [name of nurse]. 02 sat reading was all over the place, at 3L was as low as 50% and they're certain of the accuracy of the equipment. Resident was just admitted to [name of hospital] and treated for DVT. With concern for pulmonary embolism, I gave order to send her back to [hospital name] ED". R2's physician note dated 9/18/2020, at 2:25 p.m. included "NP called [nurse name], who reported that the ambulance came, EMT assessed her and found her 02 sat was normal. They stated that she's stable and did not take her to the ED. Nursing was instructed to keep a close eye on her over the weekend. 1. Take VS [vital signs 3 times daily for 3 days. Notify [provider] on call if 02 drops <90% on 1 LNC (baseline since hospitalization) or if RR [respiratory rate] >24. 2. Assess for SOB [shortness of breath], chest pain, cough, dizziness/lightheadedness, increased leg pain or swelling when taking vital signs." R2's progress note dated 9/18/2020, at 3:00 p.m. indicated the physician was notified, physician recommended sending R1 to the emergency room for further evaluation. Emergency medical services was called and upon arrival; "EMS evaluated her and decided she did not require hospitalization at this time." Physician called back and agreed to have nursing staff "monitor her closely over the weekend. If any changes occur, we are to send her in." R2's progress note dated 9/22/2020, indicated R2 was seen by the doctor, had an ultra sound that resulted in "Bilateral non-occlusive deep venous thrombosis is seen." R2's record lacked documentation of further monitoring of the right lower extremity.	2 830		

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2 830	Continued From page 20 R2's physician visit note dated 9/22/2020, indicated R2 was seen for initial physician visit. The note included a section Physical Exam; the section only included "Constitutional: She appears well-developed. Psychiatric: She has normal mood and affect." The physician ordered labs on next lab day and for nursing to continue close monitoring of the right lower extremity. R2's progress note dated 9/25/2020, at 9:22 a.m. included "Res [resident] was not responding to command. This AM. oxygen was 67 at 4 L. Her body was very cold to touch. She was covered with extra blanket and was monitored for an hour, oxygen was 56 even with nasal cannula. Ambulance was called and she was transferred to the hospital." The note lacked documentation the physician had been notified of R2's oxygen saturation less than 90% and acute change in condition. R2's progress note dated 9/28/2020, indicated family contacted the facility and reported R2 was close to death. During an interview on 10/20/2020, at 6:22 p.m. family member (FM)-A stated on 9/23/2020, she had been at work and received a call from a nurse at the facility before 4:00 p.m.; the nurse indicated R2 may be going into the emergency room for non-emergent cares. FM-A stated she arrived at the facility around 5:20 p.m. and around 6:00 p.m. the nurse told her that instead of sending R2 to the ER, R2's vascular doctor had ordered an increase in lovenox. FM-A stated that on 9/25/2020, once at the hospital a tube was put up R2's nose to pump her stomach that resulted in not a huge amount of fluid but a good amount, R2 also had blood in her stools. FM-A stated R2's death certificate included, "Complications of right hip fracture-fall, hypertension, and Alzheimer's disease.	2 830		

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2 830	Continued From page 21 On 10/21/2020, at 8:00 a.m. director of nursing (DON) reviewed R2's oxygen saturation records and stated "the monitoring and assessing of respiratory status was lacking, there was inconsistent documentation of how much oxygen she was being used therefore would not be able to ascertain worsening respiratory condition." DON stated on 9/25/2020, upon discovery of R2's 02 saturations, 911 should have been called as well as the physician instead of monitoring R2 for an hour. The DON also stated staff should have notified the family member on 9/18/2020, when they were going to send her in to allow participation in the care plan. DON then stated "progress notes and record are not complete and leave a lot of unanswered questions. There was a lack of monitoring of the lower extremity for changes in color/warmth/sensation or color." During an interview on 10/21/2020, at 3:03 p.m. registered nurse (RN)-C indicated if resident had low oxygen saturations, would check standing orders, place on oxygen and call 911 and/or physician dependent upon situation. During an interview on 10/23/2020, at 5:03 p.m. RN-B stated he was the nurse that found R2 with low oxygen saturations. RN-B stated it was an error in judgement at the time and should have called the physician and ambulance immediately. The Immediate Jeopardy was removed on 10/22/2020, at 5:45 p.m. when it was determined the facility provided re-education and competency testing to licensed nursing staff on the facility's change of condition policy with emphasis on abnormal respiratory status and signs/symptoms of pulmonary embolism. In addition, the facility developed and implemented an auditing system for respiratory monitoring. R8 CONSTIPATION: R8's significant change Minimum Data Set (MDS)	2 830		

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2 830	Continued From page 22 assessment dated 7/23/2020, indicated R8 had been admitted to hospice, did not have cognitive impairment, and did not have rejection of care behaviors. According to the MDS, R8 required extensive assistance from two or more staff members for bed mobility, dressing, and toilet use. The MDS indicated R8 was always incontinent of bowel. R8's Face Sheet, included diagnosis of irritable bowel syndrome, constipation, and heart burn. R8's care plan dated 7/17/2020, included "Resident has a terminal diagnosis and is receiving hospice services through [name of hospice agency], with the goal of "will be kept as comfortable as able with through collaboration with hospice for end of life care." Interventions included, Administer medications as ordered, monitor and document effectiveness of medication. Follow-up with hospice/provider as needed. The elimination care plan edited on 7/28/2020, indicated R8 had alteration in elimination related to decreased mobility and opioid medication with the goal of "will have no s/sx [signs/symptoms] of constipation through the review date" (goal dated 6/29/2020). The interventions included, administer medications as ordered and observe for effectiveness, see comfort/pain opioid care plan (7/28/2020), If no bowel movement in three days follow bowel protocol per standing orders (6/29/2020), Observe for s/sx of constipation: passing hard/no stools, abdominal bloating/swelling, cramping, nausea and/or vomiting, mental status changes (6/29/2020) assist of one stand pivot wheelchair to/from toilet. R8's physician orders included the following: -Morphine concentrate solution 5 milligrams (mg) as needed (PRN) by mouth every hour as needed for shortness of breath or pain (start date	2 830		

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2 830	Continued From page 23 7/18/2020, end date 8/9/2020) -Lactulose (laxative) 15 milliliters (ml) once a day PRN for constipation (start date 7/15/2020, end date 8/5/2020) -Lactulose 15 ml by mouth daily and may also take 15 ml daily as needed for constipation (Start date 7/15/2020, end date 8/5/2020) -Lactulose 30 ml twice daily (start date 8/5/2020, end date 8/11/2020) -Senna with Docusate Sodium 8.6/50 mg, take two tablets in the morning and 3 tablets at bedtime (start date 7/15/2020, end date 7/28/2020), order was changed on 7/28/2020 - take 3 tabs twice a day with a stop date 8/11/2020. -Bisacodyl 10 mg suppository once a day PRN (start date 7/19/2020, end date 8/10/2020. -Bisacodyl tablet 5-10 mg once daily PRN (start date 7/15/2020, end date 8/5/2020) -Bisacodyl tablet 5 mg by mouth once day (start date 8/5/2020, stop date 8/11/2020) -Fleet enema 19-7 gram/118 ml; 1 tube, one time dose per standing order (7/26/2020) -Fleet enema one tube, every three days PRN for constipation if no results from suppository (start date 8/2/2020, end date 8/11/2020) Miralax 17 grams once a day (start date 8/5/2020, end date 8/11/2020. Facility standing orders signed by medical director on 3/1/2019, for Bowel and Bladder Management included the following for constipation; (Perform step sequentially) Perform rectal check to determine if impaction is present, Bisacodyl suppository 10 mg per rectum twice a day for constipation. Reattempt Senna or Bisacodyl if no results after 24 hours. Fleets enema per rectum every 3 days PRN for constipation if no results from suppository.	2 830		

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2 830	Continued From page 24 R8's Medication Administration Records (MAR), in combination with Bowel Movement Record (BMR), and progress notes were reviewed. The record consistently lacked a comprehensive bowel assessments; the record did not identify physical examination such as abdominal distention, presence of bowel sounds, or firm/soft abdomen. The record identified bowel medications were not given per physician order and no follow up of effectiveness when the bowel medication was given. R8's progress note dated 7/22/2020, indicated R8 reported constipation "relieved with suppository and laxatives" had large bowel movement. R8's BMR identified R8 did not have bowel movements on 7/23, 7/24, and 7/25/2020. One PRN dose of Lactulose was administered on 7/25/2020; dose was documented as not effective, no further interventions documented. MAR indicated no PRN suppositories were administered. R8's MAR on 7/26/2020, indicated R8 was administered a Fleets enema, one time with special instructions: Day 4 no BM per standing order, with medium results. The BMR at 1:22 p.m. indicated R8 had a large bowel movement and at 7:22 p.m. had a medium bowel movement; consistency of BM was not identified on the BMR. R8's BMR included the following recordings: - 7/27/2020, medium bowel movement (no consistency identified). -7/28/2020, no bowel movement -7/29/2020, no bowel movement -7/30/2020, no bowel movement, MAR indicated PRN dose of Lactulose administered was not effective; no other intervention. -7/31/2020, no bowel movement, MAR indicated	2 830		

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2 830	Continued From page 25 Bisacodyl suppository administered day 4 no BM and was not effective. -8/1/2020, no bowel movement - 8/2/2020, R8 had medium bowel movement that was dry and hard. MAR indicated R8 was administered PRN lactulose that was not effective. -8/3/2020, no bowel movement. PRN Bisacodyl suppository and lactulose administered and was not effective. -8/4/2020, medium bowel movement that was soft/formed. MAR indicated lactulose and Bisacodyl administered and were not effective. - 8/6/2020, no bowel movement; MAR identified Miralax was administered per schedule, no PRN bowel medications administered. -8/7/2020, no bowel movement; MAR identified scheduled medications given, Bisacodyl administered and charted as effective although there was no bowel movement recorded. R8 was administered morphine 5 mg at 4:52 p.m. for bottom pain 5/10; record lacked evaluation of effectiveness. -8/8/2020, small bowel movement that was dry and hard; MAR identified Bisacodyl administered for day 4 without a bowel movement; documented as effective. R8 refused Senna S, record lacked evidence after refusal R8 was re-approached. R8 was administered Morphine 5 mg at 2:58 p.m. for discomfort when trying to have bowel movement and shortness of breath, and at 4:58 p.m. for bottom pain. - 8/9/2020, 2 small bowel movements (consistency was not identified); MAR indicated R8 refused suppository, Miralax, and Senna S. - 8/10/2020, indicated R10 had small soft/formed stool, large loose stool, and another large bowel movement. R8's progress note dated 8/2/2020, included	2 830		

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2 830	Continued From page 26 "Resident complaining of discomfort in abdomen. Has no bowel movement for 6 days. On scheduled and as needed morphine sulfate. Oral laxatives and Bisacodyl suppository ineffective. Fleets enema given as per standing order. Effective with medium hard stool. Resident verbalized relief with abdominal discomfort." The note also indicated oral laxative encouraged. R8's progress note dated 8/3/2020, hospice called to update on not eating and need for bowel medication due to constipation. R8's hospice visit note dated 8/3/2020, included "patient received suppository and nurse assist to digitally remove hard stool. Patient reports she is no longer constipated and staff confirm she had a small BM today. Bowel sounds active in to all four quadrants, abdomen soft and not tender. Writer discussed bowel regimen with facility nurse, who reports they will continue to monitor and utilize PRNs as the pt refuses to schedule more laxatives at this time despite writer's education and recommendations." The note also indicated the nurse reported the facility had been giving PRN Bisacodyl suppositories. R8's hospice note dated 8/4/2020, at 9:45 a.m. indicated family member called hospice, "stating that pt is in significant pain due to constipation, and pt is requesting to go to the hospital." The note indicated hospice called the facility and instructed the nurse to give prn dose of lactulose. Nurse reported that lactulose and suppository would be administered later that afternoon. At 12:15 p.m. the family had communicated back to hospice that a suppository and enema were used with no results, the hospice nurse called hospice physician and obtained new orders. The note indicated the facility would call hospice when R8 had results after medications were given as directed by hospice nurse.	2 830		

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2 830	Continued From page 27 R8's progress note dated 8/4/2020, at 1:09 p.m. indicated R8 reported constipation, scheduled bowel medication suppository and enema given per hospice order with small smeared results. "PRN morphine given for comfort during care, transferring, and discomfort due to constipation." The note indicated hospice was updated during visit and via phone related to bowel management. A subsequent note at 1:46 p.m. included, "STAT verbal order for another lactulose PRN per hospice for constipation placed." Note at 9:54 p.m. included, "Resident had a medium bowel movement this evening." Results were communicated to hospice nurse. R8's progress note dated 8/5/2020, indicated hospice at the facility and gave new orders; Bisacodyl 10 mg daily and increase lactulose to 30 ml twice a day. A subsequent note at 7:50 p.m. indicated staff had reported R8 had large bowel movement during evening cares. According to R8's MAR on 8/5/2020, R8 was administered Morphine 5 mg at 3:23 p.m. for rectal pain, record did not identify the effectiveness of the medication. R8's progress note dated 8/8/2020, indicated took her bowel and pain medications. A subsequent note at 8:47 p.m. indicated cream was applied to residents bottom due to discomfort after bowel movement. R8's progress notes dated 8/9/2020, at 8:25 a.m. indicated hospice was updated related to pain management due to discomfort with direction from hospice to stay on PRN medications as ordered. The note indicated R8 was administered the pain medications and had good results. A subsequent note at 4:04 pm. indicated R8 had refused her morning medications. Family member was present, asked medications be administered including lactulose and senna.	2 830		

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2 830	Continued From page 28 "Resident started to have peristalsis (the involuntary constriction and relaxation of the muscles of the intestine or another canal, creating wavelike movements that push the contents of the canal forward) which caused abdominal discomfort and pain. PRN morphine given hourly per order with less effect on pain management." The note then indicated hospice was contacted and increased morphine. R8's record lacked staffs re-attempt of administration of bowel medications after it was initially refused. R8's progress note dated 8/10/2020, at 5:51 a.m. indicated R8 had a soft small bowel movement when she was repositioned. R8's progress note dated 8/10/2020, at 1:28 p.m. (late entry documented on 8/11/2020 at 1:40 p.m.) included, "Resident restless and c/o [complained of] pain." Note indicated R8 was administered pain medication and Haldol for anxiety. "This writer brought Bisacodyl suppository to her room to administer d/t resident refusing oral bowel medications and only having small bm's. Resident refusing stating "NO, NO, NO suppository." Residents daughter was in the room at the time and agreed with residents request. Hospice here around lunch time and resident still having increased anxiety and restlessness" the note indicated the nurse tried to offer the suppository again and the resident refused. R8's hospice visit note dated 8/11/2020, included "RN did rectal check due to complaints of having rectal pain. [Name of nurse] LPN [licensed practical nurse] did not give suppository as requested by this RN on 8/11/2020 due to pt refusal. RN noted pt to have hard stool in rectum and disimpacted XL [extra large] hard stool. RN was unable to complete disimpactaction due to pt	2 830		

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2 830	Continued From page 29 have bleeding from rectum in moderate amounts (possible hemorrhoid). RN applied pressure to rectal area to slow down the bleeding. RN gave pt Dulcolax suppository to promote further BM. Bowel sounds hypoactive x 4. After pt was disimpacted, she was able to relax with no facial grimacing or restlessness noted in bed." The note also indicated the resident was transferred to hospice house. During an interview on 10/21/2020, at 8:51 a.m. nursing assistant (NA)-D stated NA's were supposed to record bowel movements, sometimes things didn't get charted, and didn't think there was a way to look back at the history. NA-D stated the nurses were supposed to make sure residents had bowel movements and administer suppositories if they didn't have one every three days. During an interview on 10/21/2020, at 9:23 a.m. NA-C stated NA's were supposed to document bowel movements however, needed work. NA-C indicated agency staff were not documenting. NA-C indicated a suppository was supposed to be given if a resident did not have a bowel movement every three days; that it was up to the nurse to administer the suppository. During an interview on 10/21/2020, at 9:34 a.m. licensed practical nurse (LPN)-A stated NA's were supposed to document bowel movements and report to the nurse if haven't had a bowel movement in 3 days or if resident complained of constipation. LPN-A stated TMA's have to check with nurses prior to holding any medications for an assessment to be completed. LPN-A stated physician's orders should be followed for bowel medications. If a bowel medication was not effective, then more follow-up was required. During an interview on 10/21/2020, at 12:16 p.m. registered nurse (RN)-A stated there was a bowel	2 830		

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2 830	Continued From page 30 movement report sheet. RN indicated the report was supposed to be pulled up during the shift; if no bowel movements in 3 days then a suppository was supposed to be given. RN indicated if it was not effective then more follow-up was supposed to be completed. RN stated a complete bowel assessment should be completed prior to the administration of bowel medications and/or when a resident would complain of constipation. During an interview on 10/21/2020, at 3:03 p.m. registered nurse (RN)-C stated a complete bowel assessment should be completed and documented prior to the administration of laxatives. RN-C indicated if no bowel movement in three days supposed to get a suppository, and if there was not results then more intervention needed to be completed. RN-C stated documentation is not always accurate, and does not always identify consistency; stated there isn't a standard for size documentation and indicated it was left up to the person recording to determine difference between small/medium/large. During an interview on 10/23/2020, at 7:42 a.m. director of nursing (DON) reviewed R8's record; and confirmed physician orders for bowel management were not followed. DON stated nursing should have followed the bowel regimen per physician orders. DON stated they should be documenting refusals and need to re-attempt to administer, if a TMA documented refusals they should have reported to a nurse and document what happened. DON stated bowel assessments should be completed when complaints of constipation and/or before administering a PRN medication. During a return phone interview on 10/29/2020, at 3:30 p.m. with nurse practitioner (NP)-B, NP-B	2 830		

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2 830	Continued From page 31 stated staff should be administering bowel medications per orders. NP-B indicated fleets enema should not be given before using the prescribed medications. NP-B stated an expectation that nurses complete full bowel assessments daily if there was constipation concerns and before administration of as needed medications. R9 FLUID OVERLOAD R9's admission Minimum Data Set (MDS) assessment dated 9/28/2020, indicated R9 did not have cognitive impairment and required extensive assistant of two or more staff for bed mobility, dressing and personal hygiene. The MDS also indicated R9 received one administration of a diuretic during the assessment period. R9's Face Sheet, included diagnoses of essential hypertension, venous insufficiency, cirrhosis of the liver (scarring of the liver), chronic kidney disease stage 3(moderate kidney damage), rheumatic tricuspid insufficiency (failure of the heart's tricuspid valve to close properly), and secondary pulmonary hypertension. R9's nutrition care plan dated 9/23/2020, identified R9 was on a fluid restriction; interventions included document meal intake %, fluids, bowel movements, and urinary output as applicable each shift. Notify licensed nurse for low intake and refused meals. R9's Hospital Discharge Summary Brief Overview dated 9/21/2020, indicated R9 was hospitalized related to anemia iron deficiency blood loss. The section Active Issues Requiring Follow-Up included primary care provider to consider starting Torsemide (diuretic) at dose of 10 milligrams (mg) based on creatinine (lab) levels. R9's physician orders included:	2 830		

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2 830	Continued From page 32 -Check heart rate, blood pressure, and Sp02 (oxygen saturations) daily (include oxygen requirement) Special instructions: Notify [name of clinic staff] if SBP (systolic blood pressure] >160 or SBP <90, HR (heart rate) >100 or <60, Sp02 <90% or increased oxygen needs, or with any other concerns (start date 9/24/2020, stop date 10/2/2020) - Check heart rate, blood pressure, and Sp02 daily (include oxygen requirement) Special instructions: Notify [name of hospital staff] if SBP (systolic blood pressure] >160 or SBP <90, HR (heart rate) >100 or <60, Sp02 <90% or increased oxygen needs, or with any other concerns. For heart rate <60 only notify provider if symptomatic (dizziness/lightheadedness or syncope (start date 10/2/2020, stop date 10/5/2020) -No added salt diet. Special instructions <1.5 fluid restriction (start date 9/21/2020) -Weight daily before breakfast. Use the same scale. Notify provider if weight gain >267 lbs. (pounds) or <261 lbs. (start date 9/28/2020. -Torsemide 10 milligrams (mg) now and then daily in the morning (start date 9/28/2020) -Apply low stretch wraps to bilateral lower extremities, on in the a.m. and off in the p.m. (start date 9/28/2020) R9's vital sign record was reviewed; the record identified heart rates under 60 without evidence the physician had been notified. 9/21/2020, 11:49 a.m. HR 56 9/22/2020, 2:59 p.m. HR 55 9/22/2020, 9:32 a.m. HR 58 9/22/2020, 6:51 p.m. HR 55 9/23/2020, 7:28 p.m. HR 57 9/24/2020, 10:26 p.m. HR 58 9/25/2020, 7:34 a.m. HR 56 9/26/2020, 12:25 p.m. HR 55	2 830		

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2 830	Continued From page 33 9/27/2020, 9:48 a.m. HR 55 R9's 24 hour fluid intake from 9/21/20 to 10/5/20, lacked documentation the facility had implemented R9's fluid restrictions on 9/23/20, 9/25/20, 9/30/20, 10/3/20 and 10/4/20. R9's daily weight record from 9/22/20 to 10/6/20 revealed R9 had not been weighed 10 of the 15 days: -9/22/2020, wt. (weight) 264.7 lbs. -9/23/2020, wt. not taken -9/24/2020, wt. 256.3 lbs. -weight not taken on 9/25, 9/26, 9/27, 9/28, or 9/29/20. -9/30/2020, wt. 274.2 lbs. -10/1/2020, wt. not taken -10/2/2020, wt. not taken -10/3/2020, 276 lbs. -10/4/2020, 276 lbs. -10/5/2020, wt. not taken -10/6/2020, wt. not taken R9's record lacked evidence of consistent monitoring and evaluation of R9's weights and edema (swelling caused due to excess fluid accumulation in the body tissues) and lacked evidence R9's physician had been notified of the increased weight to 276 until 10/6/20. R9's progress notes from 9/21/20 to 10/6/20 revealed the following: - 9/21/2020, included resident has grade I (pressure applied to area leaves an indentation of 0-2 millimeters (mm) that rebounds immediately) pitting edema in bilateral lower extremities, with wraps on from the hospital and encouraged to elevate legs when at rest. -9/22/2020, included no edema observed at this time. - 9/28/2020, indicated R9 had a telehealth appointment for evaluation of hypertension. The note indicated the physician ordered Torsemide	2 830		

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2 830	Continued From page 34 daily in morning and apply low stretch wraps to bilateral lower extremities, on in the morning off at night, ordered labs for 10/1/2020, and weigh patient daily in fasting state every morning using the same scale. -10/1/2020, at 1:09 p.m. indicated R9 had low diastolic pressure and heart rate less than 60 and symptomatic. SBAR (a communication tool) done. A subsequent note at 2:29 p.m. indicated R9 had 3+ pitting edema in both legs. -10/2/2020, at 2:29 p.m. indicated R9 had 3+ pitting edema in both legs. -10/3/2020, indicated R9 was having increased confusion, urinary frequency and yelling out, SBAR was completed and faxed for request for urine test. -10/4/2020, indicated R9 continued to yell out and had increased confusion, physician was called, physician directed to closely monitor and report any increased signs of confusion, decreased intake, fever, and did not want a urine test done right now. -10/5/2020, indicated R9 was calm and slept all night and would follow up with SBAR today. -10/6/2020, included "resident had a meeting with her provider this morning. Likely in fluid overload and needing diuresis. Provider gave order to send resident to emergency department. R9's progress notes lacked documentation of monitoring of fluid status, edema or daily weights consistently per physician orders. R9's physician notes from 9/28/20 to 10/6/20 revealed the following: -9/28/2020, R9 had a telehealth visit for evaluation of hypertension. The note included "the patient has an order for daily weights with a target range of 261-267 lb. unfortunately she has not been weighed since 9/24/2020 and her weight at that time was 256.3 lb." The note also	2 830		

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2 830	Continued From page 35 indicated her blood pressures had been running low, usually 90's systolic over 50's to 60's diastolic. The visit indicated the Torsemide was started related to hyponatremia (low sodium), labs were ordered, plan to follow-up later that week. -10/1/2020, at 9:00 a.m. "Patient does have weight parameters to notify provider if weight is less than 261 lb or greater than 267 lb. SNF [skilled nursing facility] documentation of weight has been very inconsistent. The weights that have been recorded are quite variable. She had not been weighed at the time of my video visit today and up to this point, there is nothing documented in EMR [electronic medical record]. I have made 3 separate attempts to contact SNF for today's weight. I have been unable to get a nurse at Madonna Towers." The note also included, "Patient does report bilateral lower extremity edema, worse in the right than the left. Her legs are currently wrapped." The visit note indicated the plan was to continue Torsemide for hyponatremia, ordered labs for 10/6/2020, and follow up next week. -10/5/2020, "Attempted to see the patient today. Initially she was working with therapy and on her way to the bathroom. Nursing agreed to meet me again at 11:15 a.m. to see patient. Nursing did not log on at 11:15. Received page later stating nursing was ready for me to see patient, however, nursing was not signed on. Attempted to call Madonna Towers, but could not reach a nurse. Of note patient is scheduled for follow-up tomorrow, can address UTI symptoms at that time, if nursing signs onto virtual visit. " -10/6/2020 "I had attempted to see the patient yesterday for [name of person] concern of UTI symptoms. Nursing was unavailable to assist with virtual video." Therefor the patient was seen	2 830		

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2 830	Continued From page 36 today. At time of visit she appeared lethargic and unable to answer questions other than to voice her need to urinate." The note also included, "Per nursing staff [name of nurse] patient is unwell and weak today, [name] states that patient has been confused for two days and has been experiencing urinary frequency. [Name] also states that her eyelids appear to be swollen." The note indicated R9 was alert to person and year and did not know where she was located. The note indicated the physician gave an order to transfer to emergency room for decline in condition. During an interview on 10/21/2020, at 9:23 a.m. NA-C stated NA's tried to get daily weights however, it didn't always happen because staff were busy in the morning. Stated if we miss a weight then the bath aide would attempt to get the weight on the resident. During an interview on 10/21/2020, at 9:34 a.m. licensed practical nurse (LPN)-A stated edema should be monitored daily with weight. LPN-A stated she did not think it was being documented, and it would be important to identify a change in condition. During an interview on 10/23/2020, at 7:42 a.m. director of nursing (DON) reviewed R9's record and confirmed weights were not obtained per order, lack of edema monitoring and evaluation, and the physician was not notified when heart rate was below 60 per the order. DON stated the documentation did identify if R9's was assessed for symptoms for lower heart rate. During a return phone interview on 10/29/2020, at 3:30 p.m. with nurse practitioner (NP)-B, NP-B stated completing daily weights at the facility has been an ongoing problem. NP-B stated residents were given set parameters on when to notify the physician and they were also given specific	2 830		

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2 830	Continued From page 37 directions on obtaining daily weights in the morning, before breakfast, using the same scale. NP-B indicated that in order for the resident to get the appropriate treatments nursing had to be monitoring and assessing for changes in weight, fluid balance, and swelling. A facility policy/protocol for fluid management was requested and not received. Facility policy Change in Condition dated 2/2019, included "When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative. The policy did not specifically define what constitutes a change in condition. A facility policy/protocol for bowel management was requested and not received. Facility policy Administering Medications 2/2019, included; To administer resident medications in a safe and accurate manner that will ensure the 6 rights of medication administration. Medications are administered in accordance with the orders. 3. Medications are administered within their prescribed time. Any refused medication is destroyed and documented as a refusal (did not instruct to re-attempt). Facility policy Change in Condition dated 2/2019, included "When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative. The policy did not specifically define what constitutes a change in condition.	2 830		

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2 830	Continued From page 38 SUGGESTED METHOD OF CORRECTION: The DON could do quality of care chart audits focusing on residents with acute conditions, respiratory conditions, constipation, and cardiac diagnosis in order to identify any potentia concerns. The DON could review protocals for conditions that require monitoring/assessment. The DON could then develop and implement of training/competency programs to nursing staff. The DON could develop and implement an auditing system as part of the facility's quality assurance program to monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 885	MN Rule 4658.0525 Subp. 1 Rehabilitation Nursing Care; Program required Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405. Continuous efforts must be made to encourage ambulation and purposeful activities. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff provided restorative services to meet the assessed needs for 3 of 3 residents (R11, R12, R13) reviewed for restorative services.	2 885	Corrected	12/4/20

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2 885	Continued From page 39 Findings include: R13 R13's face sheet, printed on 10/23/30, indicated diagnoses of ataxia (impaired balance or coordination) and degeneration of nervous system (loss of function or structure of nerves of the spinal cord). R13's quarterly Minimum Data Set (MDS) assessment dated 9/29/20, indicated R13 was cognitively intact, had adequate hearing and vision, clear speech, was understood and had clear comprehension. R13 required extensive assistance of one staff for bed mobility, transfers, toileting, and locomotion on and off the unit. Walking in her room or corridor occurred only once or twice. R13's care plan category called restorative nursing dated 3/25/20 indicated R13 required restorative program to address neuromyopathy (disease of nerves) and degenerative disease of the nervous system with decreased mobility. Goals and approaches indicated R13 would continue to ambulate 150 feet daily and use the NuStep (stationary bicycle) 10 minutes daily between 6:00 a.m. and 2:15 p.m. R13's point of care history report indicated the frequency of restorative nursing related to walking. The report indicated R13 ambulated zero times between 9/21/20 and 10/22/20. Three times, the report listed the reason as "refused." Other reasons included: not observed, could not assess, deferred due to condition, unavailable and unknown. During an interview on 10/22/20, at 12:45 p.m.	2 885		

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2 885	Continued From page 40 R13 stated when they had a restorative aid, she was able to use the NuStep and walk in the hall, but now that they were short staffed, this was not happening. R13 stated only two staff have asked her if she wanted to walk in the past six weeks. R13 admitted she sometimes refused to walk due to the small stature of some staff, as she doesn't feel safe with them. R13 stated she was not confident in the ability of staff providing restorative services. R13 stated, "I'm paying a lot of money to be here and they aren't always meeting my needs." R13 stated this has been brought up at resident council, "but the new management is more concerned about the bottom line then the residents." R13 stated she was not able to tell if the lack of restorative services had affected her, but expressed concern that it may eventually "catch up." R12 R12's facesheet, printed 10/23/20, indicated diagnoses of Parkinson's disease (disease affecting movement), age-related physical debility, osteoporosis (bones become weak and brittle), muscle weakness and repeated falls. R12's quarterly Minimum Data Set (MDS) assessment dated 8/18/20, indicated R12 was cognitively intact, had adequate hearing, impaired vision requiring corrective lenses, clear speech, was understood and had clear comprehension. R12 required extensive assistance of two staff for bed mobility, transfers and toileting, and required extensive assistance of one for dressing, walking in her room and locomotion on the unit. R12's care plan category called restorative nursing dated 3/24/20, indicated R12 required	2 885		

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2 885	Continued From page 41 restorative program to address Parkinson's disease with muscle weakness. Goals and approaches indicated R12 would maintain the ability to ambulate 200 feet daily and ride NuStep for 10 minutes daily, between 6:00 a.m. and 2:15 p.m. R12's point of care history report indicated the frequency of restorative nursing related to walking. The report indicated R12 walked 200 feet daily during the specified time frame only seven times between 9/21/20 and 10/22/20, and only one time did she walk 200 feet. Twice the report listed the reason as "refused." Other reasons included: not observed, could not assess, deferred due to condition, unavailable and unknown. During an interview on 10/22/20, at 1:31 p.m. R12 stated, "If they walk me once a week, I'm doing good, and I do need it. I'm getting weaker every day and I'm not going to last long at this rate. I'm not active enough." R12 stated she was not using the NuStep at all anymore. R12 stated, "They didn't renew that gal's contract so there is no one to sit with you while you do it." R12 stated she would like to walk in the hallway. R12 stated that in the morning, she would ask staff if she could walk and staff say, "Later, but later never comes." R11 R11's facesheet, printed 10/23/20, indicated diagnosis of dementia, age related physical debility, osteoarthritis (wearing down of bones) and muscle weakness. R11's quarterly Minimum Data Set (MDS) assessment dated 8/11/20 indicated R11 had	2 885		

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2 885	Continued From page 42 moderate cognitive impairment, had adequate hearing and vision, clear speech, was understood and had clear comprehension. R11 required extensive assistance of one staff for bed mobility, transfers, toileting and locomotion on and off the unit. R11 required limited assistance of one when walking in her room, and walked in the corridor with assistance of staff only once or twice. During an interview on 10/22/20, at 1:52 p.m., R11 stated she wanted to walk, "but staff don't have time." R11 stated, "I'm losing strength." R11 stated she could not recall the last time staff helped her walk. R11's care plan category called restorative nursing dated 3/25/20, indicated R11 required restorative program to address neuromyopthay (weakness, numbness and pain from nerve damage), osteoarthritis of both knees, and fibromyalgia (wide spread muscle pain) with decreased mobility. Goals and approaches indicated R11 would continue to ambulate 400 feet daily and use the NuStep 10 minutes daily between 6:00 a.m. and 2:15 p.m. R11's point of care history report indicated the frequency of restorative nursing related to walking. The report indicated R11 ambulated zero times between 9/21/20 and 10/22/20. The reasons included: not observed, could not assess, deferred due to condition, unavailable and unknown. During a telephone interview on 10/22/20, at 2:05 p.m. family member (FM)-E stated R11 was not doing very well. FM-E stated, "To get them to find the time to help her...they're understaffed like	2 885		

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2 885	Continued From page 43 everyone else and they don't have time." "FM-E could not confirm if R11 walked daily stating, "I doubt it, but I just don't know." FM-E stated, "They're overwhelmed and sympathetic, but I don't know what's happening there." During an interview on 10/20/20, at 4:45 p.m. nursing assistant (NA)-B stated she usually worked without taking a break as there was too much work to get done. NA-B stated there were only two aids to care for 30 residents, adding she had 15 residents by herself that morning. NA-B stated things that don't get done due to lack of staff included: dirty laundry, call lights, turning, walking, toileting. "I've seen lights on for an hour. It's stressful...I go home thinking about all the things I couldn't do." When asked if staff were able to provide restorative services to residents who require it, such as walking, NA-B stated, "I know it's not getting done. We don't have the staff or the time to do it." When asked how lack of restorative services might affect residents, NA-B stated, "They'll decline and that's not fair to them." During an interview on 10/21/20, at 8:42 a.m. NA-C stated she had not been able to walk residents who are on restorative programs and stated "something has to give; we can't do it all." NA-C acknowledged that restorative services were important for residents stating, "It helps with balance and strength." NA-C stated she had brought this to the attention of the DON and the DON stated they were working on hiring more staff. NA-C stated they used to have a restorative aide, but that position was eliminated and now all nursing assistants are expected to provide restorative services, such as walking, along with their other responsibilities. NA-C stated	2 885		

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2 885	Continued From page 44 restorative services did not require special training because this was something taught in NA courses. During an interview on 10/21/20, at 11:09 a.m. DON stated she had been instructing nursing assistants to complete a task and then document it in the electronic medical record (EMR) before moving onto the next task. DON explained this was important so that these tasks show up in the care history report as being done. DON stated some nursing assistants have been resistant to documenting these tasks in the EMR (electronic medical record). DON acknowledged the staffing challenges of the facility and stated she recognized that care plan interventions, such as restorative serves were not being done. DON stated she did not have time to look at resident EMR's to determine if restorative services were being done according to the care plans. DON stated when she asked staff about whether restorative serves were being done, some nursing assistants said they were doing it, some said they didn't have time to do it, and some said they forgot to document it. DON stated it was the expectation staff provided services as indicated on care plans, but acknowledged there wasn't enough staff to do it. During an interview on 10/22/20, at 11:07 a.m. corporate vice president of operations (VPO)-G stated, "In this industry, we are all staffing challenged, we are trying to ensure we have staff to meet the needs of our residents." VPO-G stated there was a culture issue at this facility and stated, "It's unfortunate where it's been allowed to go." VPO-G stated not being able to meet resident needs, was a combination of short staffing and how existing staff was working,	2 885		

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2 885	Continued From page 45 adding "leadership needed to be on the floor and providing guidance." When informed staff reported they did not have time to walk residents who are on a restorative programs because they are too busy, VPO-G stated she was not aware of some issues until they rise to a certain level. Administrator added that a lot had happened at the facility with Covid19, changes in leadership, staff quitting, and trying to rebuild, adding "we staff some pretty good ratios" and resident care concerns were more related to staff inefficiencies. Facility policy titled Restorative Program dated 2017, indicated: Purpose: To ensure residents are comprehensively assessed / reassessed for restorative needs. 1. Restorative programs were established so that each resident can attain and maintain highest physical, mental and psychosocial well-being. Restorative nursing care promotes resident's highest level of independence in activities including daily living, range of motion, ambulation and bed mobility. 2. A registered nurse will provide oversight to the program to ensure the restorative interventions are being implemented as planned. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review ambulation programs for residents in conjunction with policies and procedures. The director of nursing (DON) or designee could inservice nursing staff regarding implementation of the care plan to include completing walking programs as directed, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 885		

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2 885	Continued From page 46 (21) days.	2 885		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food items were served in a manner to accommodate known allergen for 1 of 1 residents (R5) who had a known allergy to peanuts, and history of anaphylactic reaction (a severe, potentially life threatening allergic reaction) to peanuts. This resulted in an immediate jeopardy (IJ) situation for R5 when he was served food items which contained peanuts.	2 945	Corrected	12/4/20

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2 945	Continued From page 47 The IJ began on 10/5/20, when R5, with a known allergy to nuts was served a dessert containing peanut butter. Dietary staff served a different dessert than what R5 ordered from the dietary card which listed an allergy to nuts. The administrator and director of nursing (DON) were informed of the IJ on 10/21/20 at 6:45 p.m. The facility implemented corrective action and the IJ was removed on 10/22/20 at 6:00 p.m. However, non-compliance remained at the lower scope and severity of D, isolated, no actual harm, with potential for more than minimal harm that is not immediate jeopardy. Findings include: R5's Face Sheet included diagnoses of a stroke, heart disease and dementia. R5's quarterly Minimum Data Set (MDS) assessment dated 9/17/20, indicated R5 had adequate hearing and speech, understood and was able to comprehend. R5 refused to answer questions for the brief interview for mental status (BIMS) and had no signs and symptoms of delirium. R5 was independent with bed mobility, walking, dressing and toileting. R5's care plan for nutritional status dated 10/22/18, identified an allergy to nuts, specifically peanuts and cashews. During an interview on 10/20/20, at 9:06 a.m. R5 stated he recently received a dessert containing peanut butter and stated he was allergic to peanuts. R5 stated after taking a small bite, he'd recognized the peanut taste and spit it out. R5 stated he had a "light asthma attack," adding "two hours went by and I was bent out of shape. I	2 945		

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2 945	Continued From page 48 could have died and damn right I was scared." R5 stated he didn't go to the hospital this time but added, "it took a good two days to get it out of my system." Review of R5's progress note dated 10/5/20, at 6:07 p.m. registered nurse (RN)-B documented R5 was anxious and agitated because he had a bite of a peanut which he was allergic to. R5 reported to RN-B he swallowed a small amount and when he tasted the peanut, he spit most of it out. At 7:04 p.m. RN-B contacted a provider and received an order for epinephrine injectable to be given only if R5 was symptomatic. R5 had no symptoms of shortness of breath, rash or gastrointestinal symptoms. R5 was monitored closely and did not develop signs or symptoms of an allergic reaction and did not require epinephrine. A prior incident from 9/28/19 at 6:40 p.m., was documented in the record indicating the severity of R5's reaction to nuts. The documentation included: "Rt [resident] reported that he had ingested the dessert that had peanut butter in it. Rt. has a documented allergy to nuts. Rt. stated he had a small bite. Rt reported an upset stomach. Rt. unable to state symptoms of last allergic reaction but when asked if his mouth or tongue swelled up he responded, 'yes'. Rt. remained A x O x 4 (alert and oriented times 4) and was able to answer all questions clearly. No rash, difficulty breathing, itching or mouth swelling noted. VS WNL (vital signs within normal limit) see chart. On call for [doctor name], [doctor name] notified and gave orders to send pt. to ER via [ambulance name] emergently. Pt's contact [name], notified. Report called to [name of hospital] ER."	2 945		

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2 945	Continued From page 49 During an interview on 10/21/20, at 9:48 a.m. cook (C)-C stated all food is made in the main kitchen and then delivered to the kitchen at the nursing home, referred to it as "nursing care kitchen." C-C stated some foods came from the main kitchen with nuts in them and it was up to the server to make sure R5 did not receive them. C-C stated R5 had requested a butterscotch bar for dinner on 10/5/20, but received a scotch-a-roo bar which contained peanut butter. C-C did not know how this occurred. During an interview on 10/21/20, at 9:53 a.m. culinary services director (CSD)-A stated residents were given a paper menu at breakfast to fill out for the next day. For residents with food allergies, their menus were customized to include their allergies; CSD-A verified R5's menu listed his allergy to peanuts. CSD-A was aware of the incident on 10/5/20, when R5 received a dessert containing peanuts (a scotch-a-roo bar). CSD-A verified "R5 ordered the proper product, but we sent the wrong one." In addition, CSD-A stated on 10/17/20, R5 requested an oatmeal cookie on his menu, but a Monster cookie containing peanuts was placed on his tray. The error was discovered in the nursing care kitchen and R5 did not receive the cookie containing peanuts. CSD-A verified there was nothing in place for culinary staff to know specific ingredients in food items to ensure a resident does not receive food for which they were allergic. When asked if an incident report had been completed when R5 received food for which he was allergic, CSD-A stated it would be a grievance filed by the social worker (SW). When asked how the SW would learn about this incident, CSD-A stated he didn't know.	2 945		

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2 945	Continued From page 50 During an interview on 10/21/20, at 11:03 a.m. SW-A stated she heard about R5 receiving the scotch-a-roo bar made with peanut butter at a leader meeting. SW-A stated it was up to the person who discovered the event to fill out an incident report, adding "in this case, it was nursing." During an interview on 10/21/20, at 11:09 a.m. the director of nursing (DON) stated she was not aware R5 received a dessert which contained peanuts on 10/5/20. The DON stated the nurse on duty that evening RN-B, was an agency nurse and added, "I'm surprised I wasn't notified." The DON stated she would follow up with RN-B. During an interview on 10/21/20, at 6:35 p.m. lead cook (LC)-B stated all food was made in the main kitchen of the facility and delivered in metal containers to nursing care for distribution. LC-B provided a document displaying the menu for "fall week 1, Thursday" which indicated the quantities of food items to send to nursing care. While the document did not indicate ingredients for any food items, LC-B stated nursing care was responsible for determining resident allergies. On 10/21/20, at 6:45 p.m. dietary aide (DA)-A stood in the kitchen at the steam table, as he placed the entrees onto individual plates and handed the plate to an aide who set the plate on a tray and added cold food, beverages and dessert items to each tray. DA-A stated pans of food were delivered to the nursing care kitchen from the main kitchen in steel containers and put in steam wells. DA-A stated desserts arrived plated with plastic over the top, in a tall enclosed cart on wheels. DA-A stated staff looked at the	2 945		

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2 945	Continued From page 51 individual resident's paper menu and diet card in order to plate the food accurately. Resident diet cards included name, room number, allergies, likes, dislikes and food preferences. DA-A verified R5's diet card indicated an allergy to nuts: cashews and peanuts. DA-A stated he was working the evening of 10/5/20, when R5 received the scotch-a-roo bar. DA-A was unaware the kitchen brought over scotch-a-roo bars and stated he thought the bars looked like butterscotch bars. DA-A stated staff went by the menu to determine the food being served and on 10/5/20, there was no indication they were serving scotch-a-roo bars. During an interview with dietary staff on 10/21/20, at approximately 6:55 p.m., dietary aides (DA)-B, (DA)-C and (DA)-D, indicated they did not know there were nuts or peanut butter in scotch-a-roo bars. In addition, they were not able to articulate the difference in appearance between butterscotch bars and scotch-a-roo bars. The dietary aides verified no one had talked with them following the incident on 10/5/20. They further stated there were no changes made to prevent it from occurring again, nor did they receive new training. DA-B stated they talked among themselves that night and just decided they needed to be more careful. During an interview on 10/22/20, at 12:51 p.m. CSD-A stated after the first incident with R5 she "told staff not to change the menu on their own." CSD-A went on to say there was only one dessert that day and it was supposed to be butterscotch bars, but it was changed to scotch-a-roo bars. CSD-A verified scotch-a-roo bars were periodically served to residents in	2 945		

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2 945	Continued From page 52 nursing care and when asked how staff would know they contained peanut butter, he verified "they wouldn't." The facility policy titled Meal Tray Identification, dated 2012 indicated: A tray card (or approved alternative) is provided for each resident receiving meals from the culinary services department, to ensure that meal conforms to physician diet order and that likes, dislikes and individual special needs of the resident are being met. The culinary services director is responsible for providing an accurate tray card for each resident, with diet conforming to physician order, and which contains the following minimum information, updated as needed: --Name (first and last) --Room number --Diet exactly as physician ordered --Beverage preference --Food preferences --Known food allergies --Special needs (e.g., adaptive devices, salt substitute) The tray card will remain with the corresponding tray throughout the meal service." The immediate jeopardy that began on 10/5/20, was removed on 10/22/20, at 6:00 p.m. when it could be verified through observation the facility had implemented a new process to ensure residents were not served food for which they were allergic. Staff were observed to conduct a pre-meal service huddle to review resident diet changes, a red dot was added to diet cards to bring attention to food allergies. Review of diet cards and food menus were followed by staff to ensure adherence to resident food allergies and	2 945		

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2 945	Continued From page 53 preferences. During meal service, food items which contained known resident allergens were labeled in order for staff to avoid serving them. In addition, the facility conducted a verification of food allergies on diet cards against food allergies identified in the resident's electronic medical record. Staff education on the meal tray identification policy, including utilization of diet cards, began on 10/22/20, continuing for staff to be conducted prior to the next scheduled shift staff worked. A communication book for staff had been established to identify resident diet changes. Lastly, an audit was conducted by the culinary manager or designee, of diet cards to verify they were accurately labeled for diet accuracy and food allergens. Audit results were reported to the quality council. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to assistance with eating and provide staff education related to the care of residents who use require special diets related to allergies. The director of nursing or designee could develop an audit tool to ensure appropriate appropriate assistance and equipment are provided to promote resident independence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 945		
21520	MN Rule 4658.1300 Subp. 1-4 Medications and Pharmacy Services; Definition	21520		12/4/20

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21520	Continued From page 54 Subpart 1. Controlled substances. "Controlled substances" has the meaning given in Minnesota Statutes, section 152.01, subdivision 4. Subp. 2. Schedule II drugs. "Schedule II drugs" means drugs with a high potential for abuse that have established medical uses as defined in Minnesota Statutes, section 152.02, subdivision 3. Subp. 3. Pharmacy services. "Pharmacy services" means services to ensure the accurate acquiring, receiving, and administering of all drugs to meet the needs of each resident. Subp. 4. Drug regimen. "Drug regimen" means all prescribed and over-the-counter medications a resident is taking. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure resident's medications were available for administration per physician orders for 2 of 3 residents (R1 and R9) reviewed for medication errors. Findings include R1's Face Sheet provided by the facility on 10/23/2020, included diagnoses of hepatic failure, alcoholic cirrhosis of liver, diabetes type 1, dementia without behavioral disturbance, and constipation. R1's elimination care plan dated 8/4/2020, included is taking lactulose; goal of 2-3 bowel movements per day due to cirrhosis. R1's physician orders included: -Lactulose solution 30 ml three times a day for	21520	Corrected	

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	00419	A. BUILDING: _____ B. WING _____	C 10/23/2020

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21520	Continued From page 55 constipation (start date 8/19/2020). -Hydrocortisone 5 milligrams (mg); administer 1-2 tablets three times a day (start date 8/19/2020) -Glucosamine-chrondroitin 500-400 mg twice a day (start date 8/19/2020). R1's medication administration record (MAR) identified multiple doses of lactulose were not given related to the medication not available. -8/4/2020, MAR- one dose was not administered: drug/item unavailable. -8/5/2020, MAR - 3 of 3 doses were not administered: drug/item unavailable. -8/6/2020, MAR - 2 of 3 doses were not administered: drug/item unavailable. -8/30/2020, MAR - 2 of 3 doses not administered; drug/item unavailable. -9/15/2020, MAR - 1 of 3 doses not administered; drug/item unavailable. -9/27/2020, MAR - 2 of 3 doses not administered; drug/item unavailable. Hydrocortisone -10/7/2020, MAR - 1 of 3 doses was not administered: drug/item unavailable Glucosamine -Chrondoitin -8/22/2020, MAR- 2 of 2 doses were not administered: drug/item unavailable. R9 R9's Face Sheet provided by the facility on 10/23/2020, included diagnoses of essential hypertension, venous insufficiency, cirrhosis of the liver, Chronic kidney disease stage 3, rheumatic tricuspid insufficiency, and secondary pulmonary hypertension. R9's physician orders included:	21520		

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21520	Continued From page 56 -Amitriptyline 2%-ketamine 5% -lidocaine 2% in lipoderm cream, apply to bilateral knees 1 gram topically two times a day (Start date 9/28/2020). -Nystatin powder 100,000 unit/gram; one application four times a day (start date 9/21/2020) -Hydrocortisone cream 2.5% Mix 1:1 with Ketoconazole and apply to the effected area twice a day (start date 9/21/2020, stop date 10/3/2020) R9's medication administration record (MAR) identified the medicated cream/ointments were not available to administer per physician orders. Amitriptyline cream Medication administration record (MAR) on 10/5/2020, medication was not administered; drug/item unavailable. Nystatin MAR 9/21/2020, 2 of 4 application not administered; pharmacy won't send and drug/item unavailable. MAR 9/22/2020, 4 of 4 applications not administered; drug/item unavailable. MAR 9/23/2020, 1 of 4 application not administered; drug/item unavailable. MAR 9/28/2020, 2 of 4 applications not administered; drug/item unavailable Hydrocortisone cream MAR 9/21/2020, 2 of 2 applications not administered; drug/item unavailable new admit med unavailable, and pharmacy won't send. MAR 9/22, 9/23, 9/24, 9/25/2020, 2 of 2 applications were not administered; drug/item unavailable MAR 9/26/2020, 1 of 2 applications not	21520		

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21520	Continued From page 57 administered; drug/item unavailable. MAR 9/27/2020, 1 of 2 applications not administered; drug/item unavailable MAR 9/30/2020, 1 of 2 applications not administered; drug/item unavailable. MAR 10/2/2020, 1 of 2 applications not administered; drug/item unavailable. During an interview on 10/19/2020, at 9:37 a.m. trained medication assistant (TMA)-B stated if a medication was not available then then supposed to let the nurse know; if it's not ordered then we are supposed to order it. TMA-B indicated an unawareness if it was considered a medication error if the medication was not available from pharmacy. During an interview on 10/20/2020, at 11:16 a.m. director of nursing (DON) indicated if medications were not available for administration, it was considered a medication error. The DON stated a medication error report should have been completed, the physician should have been notified, and the pharmacy contacted. During an interview on 10/21/2020, at 2:35 p.m. Allixa pharmacy technician (PT) stated medications were delivered to the facility, if there was a medication not available then staff would just give when the medication was available. PT confirmed pharmacy delivery services were available 24/7, however facility staff would have to communicate they wanted the medication immediately. PT stated if the pharmacy did not have the medication, facility staff should notify the physician; omission of medication was considered medication error. During an interview on 10/22/2020, at 9:34 a.m.	21520		

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21520	Continued From page 58 licensed practical nurse (LPN)-A stated if a medication was not available it was considered a medication error and the nurse should be notified. LPN-A indicated the pharmacy should be contacted. LPN-A stated if the primary pharmacy did not have the medication then we would call the back-up pharmacy. 10/23/2020, at 8:30 a.m. director of nursing (DON) stated if a medication was not available for administration then the physician needed to be notified. DON stated the facility had a 24/7 pharmacy and a back-up pharmacy; medications should be available for administration when they are scheduled. During a return phone interview on 10/29/2020, at 3:30 p.m. with nurse practitioner (NP)-B, NP-B indicated an expectation medications were at the facility for administration per physician order and expected to be notified the medication was not available. NP-B indicated an unawareness that R1's lactulose was not administered because it was not available. The Accepting Delivery of Medications policy dated 9/2018, included 2. The nurse reconciles the medication delivered against the pharmacy order listing/ticket. 3) If any discrepancies are noted the nurse notifies the pharmacy. Nurse will follow the directions of the pharmacy for correcting any error ...Documentation will be completed on the pharmacy order ticket. 6. Appropriate notifications completed if medication errors occur. Suggested Method of Correction: The administrator or designee could review the	21520		

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21520	Continued From page 59 pharmacy policy and revise systems to improve the delivery of medications for each resident. Provide training for pharmacy staff and facility staff regarding these systems and could monitor the medication delivery system to assure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days	21520		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error	21545		12/4/20

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21545	Continued From page 60 that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R1 and R4) reviewed for diabetic management were provided adequate diabetic care in accordance with current standards of practice. This practice, including inaccurate insulin administration, inadequate monitoring and notification of the physician, resulted in an immediate jeopardy situation for R1. The immediate jeopardy began on 8/5/20, when R1 required emergent care due to hypoglycemia (low blood glucose level) due to a failure of the staff to monitor and assess the resident's diabetic status and was identified on 10/21/20. The administrator, director of nursing, interim infection preventionist, and culinary director were notified of the IJ on 10/21/20, at 12:45 p.m. The IJ was removed on 10/22/20, at 5:45 p.m., but	21545	Corrected	

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21545	Continued From page 61 non-compliance remained at a lower scope and severity level of G, a pattern with actual harm but is not immediate jeopardy. In addition, the facility failed to ensure appropriate indication for Lactulose and failed to administer per physician orders for 1 of 3 residents (R1) reviewed for medication errors. Findings include: R1's Face Sheet, included diagnoses of type 1 diabetes, hepatic [liver] failure, alcoholic cirrhosis of the liver and dementia without behavioral disturbance. R1's admission Minimum Data Set (MDS) assessment dated 8/7/20, indicated R1 had severe cognitive impairment, was independent with eating, and required insulin. MDS dated 8/24/20, indicated, R1 required one person physical assist and supervision for eating. R1's diabetic care plan revised on 8/27/20, indicated R1 had type 1 diabetes that required insulin. R1 goals included, "Will have no complications r/t [related to] diabetes and blood	21545		