DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2024

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: CCN: 245189
Cycle Start Date: November 30, 2023

Dear Administrator:

On January 26, 2024, we notified you a remedy was imposed. On February 27, 2024, the Minnesota Departments of Health and Public Safety 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 February 9, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 10, 2024, did not go into effect. (42 CFR 488.417 (b))

In our letter of January 26, 2024, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 13, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 9, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Correction of the Life Safety Code deficiency(ies) cited under K222, K271, K341 at the time of the November 30, 2023 standard survey, has not yet been verified. Your plan of correction for this deficiency / these deficiencies, including your request for a temporary waiver with a date of completion of November 29, 2024, has been approved. Failure to come into substantial compliance with this deficiency / these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 7, 2024

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

Re: Reinspection Results
Event ID: 2RBE12

Dear Administrator:

On February 27, 2024, 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 November 30, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2024

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

RE: CCN: 245189
Cycle Start Date: November 30, 2023

Dear Administrator:

On December 13, 2023, we informed you that we may impose enforcement remedies.

On January 12, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 10, 2024.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 10, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 10, 2024.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 10, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Southview Acres Healthcare Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 10, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 30, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2024

Administrator
Southview Acres Healthcare Center
2000 Oakdale Avenue
West Saint Paul, MN 55118

Re: State Nursing Home Licensing Orders
Event ID: 2RBE11

Dear Administrator:

The above facility was surveyed on January 10, 2024 through January 12, 2024, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245189	A. BUILDING _____ B. WING _____	C 01/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW ACRES HEALTHCARE CENTER	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(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 1/10/24 through 1/12/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H51898785C (MN000999812) with deficiencies issued at F572, F656, F684, F609, F686 and F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 572 SS=D	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally	F 572		2/9/24

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

Electronically Signed | 02/03/2024

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

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F 572	Continued From page 1 and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a non-English speaking resident was provided with appropriate interpretive services for 1 of 3 residents (R1). In addition, the facility failed to reevaluate the effectiveness of the services offered, allowing them to be fully informed about their health status in an emergent situation. Findings include: R1's Face Sheet identified R1 had diagnoses that included anoxic brain damage, nuclear cataract, unspecified hearing loss in the left ear, repeated falls, and syncope and collapse. R1's admission assessment dated 12/19/23, identified R1 was a Cantonese speaker and required the use of an interpreter. R1 had moderate difficulty with ability to hear and no hearing aids or appliances are normally used. Admission summery identifies R1's family member (FM)-A was available and helped with admission assessment and was available anytime to help with interpreting task. FM-A informed facility staff resident was hard of hearing and IPad interpretation might not help much.	F 572	F 572 R1 has since passed away. All current residents who require interpretive services, their care plan will be reviewed and updated as needed to include care plan intervention for use of communication cards and if the resident prefers to have family or language line interpretive services. Future residents upon admission, the resident will be assessed for visual, language, hearing or communication deficits via the nurse admission assessment and will be evaluated by the appropriate therapist as needed and will be given the appropriate tools to communicate with staff and the individualized resident care plan interventions will be implemented. Facility staff will be in-serviced on the Translation and/or Interpretation of Facility Policy with emphasis on item #1 that staff will be notified that resident requires interpretative services and completion of the interpreter consent form if family member will interpret for the resident. This consent will be entered into the resident communication care plan intervention.	

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 572	Continued From page 2 R1's Minimum Data Set (MDS) dated 12/25/23 identified R1 as preferred language of Chinese and yes was answered if R1 needed or wanted an interpreter to communicate with a doctor or health care staff. R1's care plan dated 12/28/23 identified R1 had impaired cognitive function/dementia or impaired thought process due to impaired decision making. R1 spoke Cantonese and required interpretive services. R1 was unable to use interpreter pad (electronic tablet) due to hearing. FM-A was able to interpret for resident. R1 had a hearing impairment/a potential and intervention included FM-A help with hearing issues. R1's medical record lacked evidence if the facility had obtained other language interpretative services or modalities to assist with R1's communication needs. During interview on 1/12/24 at 9:36 a.m., licensed practical nurse (LPN)-D indicated being part of the admission assessment and R1 required the use of an interpreter. Facility staff were supposed to use the IPad for communication and if not successful to use FM-A to interpret. The assessment was completed with the use of FM-A and R1 could usually understand with the use of interpreter. If FM-A was not present. R1 could sometimes follow gestures. During interview on 1/11/24 at 4:25 p.m., director of social services (SW)-A indicated communication with R1 was very difficult. SW-A had only communicated through the use of FM-A interpreting. SW-A provided a Cantonese picture board for communication to R1, however declined	F 572	Director of Nursing and/or designee is responsible for compliance. Audits on communication care plans and staff competency of language line and facility-based language interpreter app along with resident consent for interpreter service will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 02/09/2024	

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 572	Continued From page 3 attempting to use it or determine if it was successful. Cantonese picture board was not care planned, however staff were to use family and caregivers to be resources for communication. SW-A was unsure of what staff were supposed to do for communication in the middle of the night or if FM-A was unavailable. During interview on 1/10/24 occupational therapist (OT)-A indicated R1 had a language barrier and did not speak English and R1's hearing was not the best. OT-A was unaware who initiated the communication board in R1's room, however typically used FM-A to interpret for therapy sessions. If FM-A was not present OT-A would use basic visual demonstrations for return demonstration in therapy. OT-A stated formal cognitive testing was not completed due to language barriers and R1 being hard of hearing. OT-A was unsure what or how R1 would respond in an emergency situation or in the middle of the night if FM-A was unable to interpret. During interview on 1/10/24 at 3:52 p.m., nursing assistant (NA)-A indicated R1 typically slept throughout the night and communication was not typically needed on the overnight shift. When R1 fell and was found on the floor during the night shift on 1/5 into 1/6/24 R1 did not have interpretive services and communicated by gestures indicating he was cold and wanted to lay down. During interview on 1/10/24 at 1:33 p.m., LPN-A indicated upon finding R1 on the ground was initially unsure if R1 was sleeping on the ground and confused or if R1 had fallen. LPN-A indicated that R1 was non-English speaking and was unable to do full assessments following the fall.	F 572		

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F 572	Continued From page 4 During interview on 1/12/24 at 5:07 p.m. DON and administrator indicated all residents that have the right for communication services and facility staff should re-evaluate the effectiveness of communication and language barriers. Policy and procedure titled Translation and/or interpretation of facility service dated 12/8/21 identifies facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. 1. When encountering LEP individuals, staff members will conduct the initial language assessment (e.g., "I Speak Cards") and notify the staff person in charge of the language access program. 2. Interpreters and translators must be appropriately trained in medical terminology, confidentiality of protected health information, and ethical issues that may arise in communicating health-related information. a. Family members and friends shall not be relied upon to provide interpretation services for the resident, unless explicitly requested by the resident. If family or friends are used to interpret, the resident must provide written consent for disclosure of protected health information.	F 572		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		2/9/24

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SOUTHVIEW ACRES HEALTHCARE CENTER	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

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F 610	Continued From page 5 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a thorough investigation regarding a fall for 1 of 1 residents (R1) reviewed for falls. Findings include: Vulnerable adult maltreatment report submitted to the State Agency dated 1/8/24, identified R1 was discharged from hospital on 12/19/23 and admitted to transitional care unit (TCU). R1 was readmitted to hospital on 1/6/24 . R1 was diagnosed with subdural hematoma, subarachnoid hemorrhage, parietal skull fracture, deep tissue injury to left heal, pressure injury to the coccyx. None of these conditions were present at the time of discharge on 12/19/23. R1's face sheet identified R1 had diagnoses that included Anoxic brain damage, nuclear cataract, unspecified hearing loss in the left ear, repeated falls, and syncope and collapse. R1's care plan dated 12/28/23, identified R1 spoke Cantonese and required and interpreter.	F 610	F 610 R1 has since passed away. All current and future resident falls from survey exit until present will be thoroughly reviewed for root cause, the resident care plan will be reviewed and updated with appropriate interventions and a fall risk assessment will be completed. All falls with injury will be reported per the facility Abuse, Neglect, Exploitation or Misappropriation, Reporting and Investigating policy. Facility IDT team will be in-serviced on the facility Abuse, Neglect, Exploitation or Misappropriation, Reporting and Investigating policy with emphasis on thoroughly investigating all resident incidents involving injuries of unknown source. Director of Social Services and/or designee is responsible for compliance. Audits on completion of the resident risk management incidents incident including the incident description, immediate intervention and witness statements tab completion will begin weekly x 4 weeks	

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F 610	Continued From page 6 Interventions included R1 unable to use interpreter iPad due to hearing. Son was able to interpret for resident. R1's abuse care plan dated identified R1 was at risk for potential abuse due to current medical condition, need for assistance with cares and mobility. Staff were to anticipate needs, assist R1 in completing treatment plan and discharge planning. Staff were to remove R1 from potentially dangerous situations. R1's incident report dated 1/6/24, indicated at 5:30 a.m. R1 was found laying on the floor on his right side at the back of his room door. Resident hit the back of his head as a result of the fall. Resident had a laceration about the size of a dime. Resident was unable to provide explanation regarding cause of the incident as he did not speak English. Resident was shivering with a blanket partially covering his body. Nursing assistant reported the last time she checked on resident he was sleeping soundly in bed. Description of immediate action taken, physical assessment completed, initial vitals signs collected. Writer was unable to collect pain assessment. Resident was assisted back to bed with the use of a Hoyer lift by two nursing staff. Level of pain rated at a score of three with facial expressions being sad, frightened, frowned body language tensed, distressed pacing, conceivability distracted or reassured by voice or touch. There were no predisposing environmental factors, physiological factors. Predisposing situation factors included using walker, call light within reach, ambulating without assist. Notes dated 1/8/24, interdisciplinary team IDT review of fall indicated patient last observed less then 60 minutes prior to fall or roll out of bed. Care plan followed. Patient did have a history of laying very closet o side of bed. Will look at and change care	F 610	then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 02/09/2024	

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F 610	Continued From page 7 plan when R1 returns from emergency room and can get input from family member. During interview on 1/10/24 at 3:29 p.m., director of nursing (DON) reported she was notified of the fall on 1/6/24 at 11:27 a.m. by registered nurse (RN)-A and not immediately. The investigation involved asking RN-A if the care plan was followed at the time of the fall, the last known "well time," and if there was anything suspicious regarding the fall. DON indicated R1's last known "well time" was approximately 4:30 a.m., an hour before the fall. The nursing assistant (NA) who was involved was NA-B, however, DON did not have time to confirm if the last "well time" was accurate. DON did confirm NA-B did complete documentation in R1's medical record. DON was unaware of the last time R1 was toileted as it was not documented. DON did not identify anything suspicious regarding the event of the fall based off conversation with the next day's charge RN. DON indicated the facility handled the fall and everything was completed appropriately with no concerns following proper protocol and the care plan was followed. DON indicated R1 had a history of falling very close to his bed prior to admission so the causal analysis was R1 rolled out of bed and crawled to the door. DON stated she did not complete any interviews with nurses or nursing assistants that worked on shift the night of the fall. DON indicated to be unaware of R1's status in the hospital but someone to her reported "he is doing far better then expected." During interview on 1/10/24 at 4:16 p.m., RN-A declined working on the night of the event and was not physically present and worked the following day shift.	F 610		

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F 610	Continued From page 8 During interview on 1/10/24 at 3:52 p.m., NA-A indicated she was the NA who had responded to R1's fall. NA-A reported licensed practical nurse (LPN)-A had told her R1 had fallen. When NA-A entered R1's room his head was against the door. R1 had blood on his head, both hands, spots of blood on the floor, and blood on the door of the bathroom. NA-A indicated it looked as though R1 was coming out of the bathroom himself and fell hitting his head on the bathroom door. NA-A indicated R1 had gotten a blanket somehow as it was over him. R1 said he was cold, he was in a hospital gown and shivering. NA-A transferred R1 from the floor to a standing position with the use of a transfer belt and walked him with a walker from the entrance of the room to his bed. NA-A was unaware of the last time R1 was toileted, but felt R1 had gotten up to go use the bathroom alone and fell. NA-A stated the director of nursing, clinical manager or administrator had not asked any questions about the event since the date of the fall. During interview on 1/10/24 at 1:33 p.m., licensed practical nurse (LPN)-A indicated to be R1's nurse the night of the fall and the last time being in R1's room was to give intravenous therapy (IV) medications (fluids). LPN-A reported R1 was COVID positive and R1's bedroom door had been closed. Around 5:30 a.m. LPN-A went to check on R1 and attempted to open the door a few times but noted resistance. LPN-A was able to gain visual entrance to the room and visualized R1's head against the backside of the door causing the resistance. R1 was laying on the floor and had a blood smear and a laceration (cut) on the back of his head. R1 was breathing fast and shaking. LPN-A noted blood smears and drops of blood around the bathroom and entrance to the room.	F 610		

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F 610	Continued From page 9 LPN-A indicated it was as if R1 was coming out of the bathroom had fallen and was positioned between the room entrance and bathroom entrance. LPN-A left R1 unattended to go get assistance from NA-A and asked when NA-A last provided cares and timing however timing reports were inconsistent. NA-A denied toileting R1 on last visual check due to R1 sleeping and reported R1 was supposed to use the call light. NA-A went back to assist R1 and LPN-A went to nurses station and called NP, 9-1-1, and nurse manager. LPN-A reported it was an unwitnessed fall with a head strike and R1 was on anticoagulation. LPN-A went back into the room to complete vitals and assess R1, however did not witness R1 being transferred off the floor. During interview on 1/11/24 at 2:30 p.m., licensed practical nurse (LPN)-B reported she helped LPN-A with R1 the night of the fall. LPN-B was in R1 ' s room at around 12:30 a.m. to provide intravenous (IV) medication. R1 was awake at 12:30 p.m. and was in bed the whole time during the interaction. The second time LPN-B was in the room was after R1 had fallen and was already transferred back into bed, however did not have details of the transfer. LPN-B indicated LPN-A had not called 9-1-1 at that time so instructed for LPN-A to call 9-1-1, NP and family. LPN-B reported the time she entered the room following the fall was around 5:00. During interview on 1/11/24 at 11:14 a.m., DON and Administrator, both indicated they had not reviewed the facility's video footage as part of the fall investigation. DON stated she did not report the fall with major injury because the care plan was being followed. DON ascertained that information through the investigation that	F 610		

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F 610	Continued From page 10 consisted of interviewing dayshift charge nurse (RN-A) and the incident report. According to her interview and the documentation of the event the nursing assistant had reported checking on him an hour before the fall occurred. DON stated she checked the NA charting, however the time documented of that check, was documented after R1 had left the facility. DON did not interview any other staff members including the staff that had worked when the fall occurred. Facility hallway camera video footage review completed on 1/11/24 at 11:45 with DON and administrator. The video was inconsistent with the facility's incident report and the investigation that was completed. Video revealed the following key elements such as when R1 had been last checked on before the fall, the actual time of the fall, the nurse not entering the room after she found R1 on the floor, and the mechanical lift never pushed into R1's room to get him off the floor: - 12:37 a.m. LPN-A and LPN-B are in and out of the room 12:42 a.m. LPN-B exits room and 12:45 a.m. LPN-A exits rooms. - 12:45 a.m. to 4:40 a.m. staff are noted to be in hallway, however door closed and no visual checks completed. - 4:41 a.m. LPN-A noted to be at R1's bedroom door pushing on door and appears to have a difficult time opening it. LPN-A was able to gain entrance with head to visually see in room, however did not enter room. LPN-A walks away from room with hands down at side in an unrushed manner. - 4:42 a.m., NA-A enters room and at 4:45 a.m. a plastic bag gets placed outside of the doorway - 4:49 a.m., NA-B gowned with personal protective equipment (PPE) and brought a full	F 610		

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F 610	Continued From page 11 body mechanical lift to the doorway of the room. Mechanical lift never enters room and then gets placed along the side of the hallway wall. NA-B did not enter the room. - 4:53 a.m., LPN-A enters room with vital signs machine. NA-A exits room with linen in hand and returns to room with pillow and pillowcase. 4:56 a.m. NA-A exits room 5:02 a.m. LPN-A exits room. - 5:05 a.m. LPN-B enters room 5:08 a.m. exits room. - 5:29 a.m. paramedics arrive, 5:31 a.m. paramedics enter room, 5:34 a.m. R1 leaving with EMS During interview on 1/11/24 at 1:16 p.m., following the video review; DON indicated the camera footage to actual time may vary by 15-30 minutes. Based on the camera footage R1's first and last visual check and last known "well time" before the fall was at 12:45 a.m. when nurse left the room. LPN-A did not immediately fully enter the room after observing R1 on the floor to complete a physical assessment and left R1 alone. The full body lift was never entered the room to get R1 off the floor. The mechanical lift never entered the room to get R1 off the floor. Facility policy titled Abuse, neglect, exploitation or misappropriation reporting and investigating policy dated 3/22/23 identifies all reports of resident abuse including injuries of unknown origin and neglect are reported to local, state and federal agencies as required by current regulations and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 1. All allegations are thoroughly investigated. The	F 610		

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F 610	Continued From page 12 administrator initiates investigations. 2. Investigations must be conducted with 2 persons present. 3. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. 7. The individuals conducting the investigation as a minimum: a. reviews the documentation and evidence; b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; d. interviews the person(s) reporting the incident; e. interviews any witnesses to the incident; f. interviews the resident (as medically appropriate) or the resident's representative; g. interviews the resident's attending physician as needed to determine the resident's condition; h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members, and visitors; j. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly. d. Witness statements are obtained in writing, signed and dated. The witness may write his/her statement, or the investigator may obtain a statement.	F 610		

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F 656	Continued From page 13	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		2/9/24

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F 656	Continued From page 14 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop comprehensive care plans including a toileting plan of care, a pressure sore plan of care, and a skin integrity plan of care for 3 of 3 residents (R1, R4, R5) reviewed for comprehensive care planning. Findings include R1's face sheet identified R1 had diagnoses that included Anoxic brain damage, nuclear cataract, unspecified hearing loss in the left ear, repeated falls, and syncope and collapse. R1's minimum data set (MDS) dated 12/25/23, identified R1 as preferred language of Chinese, R1 wanted or needed an interpreter to communicate with a doctor or health care staff. Brief interview for mental status (BIMS) was not completed. R1 required substantial to maximum assist for toileting. R1 had not had a trial of a toileting program and R1 was frequently incontinent of bladder and always incontinent of bowel. A toileting program was not being used to manage the residents continence R1's bowel and bladder program screener dated 12/19/23, R1 never voided appropriately without	F 656	F 656 R1 has since passed away. R4 and R5 had a toileting plan and a pressure injury care plan with interventions initiated. All residents with pressure injuries and that are incontinent will have their care plans reviewed and updated as needed. Current residents who are candidates for bladder training will have a toileting plan created and care plan interventions initiated and/or updated as needed. Future residents who are incontinent and residents that have pressure injuries will have care plans initiated and initiated per resident assessment and the comprehensive care plan (CAA) care plan trigger. The IDT team will be in-serviced on the Care Plans Comprehensive Policy with emphasis on resident assessment completion, reviewing the assessment scoring categories from the screener and pressure formal assessment along with information from the Care Area Assessment to assist with development a personalized care plan focus, goals, and interventions. The wound Nurse Practitioner along with the physician nurse	

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F 656	Continued From page 15 incontinence, incontinent of stool daily, required assist of one person to get to the bathroom, was alert and oriented, and sometimes mentally aware of the need to toilet. The screener identified R1 was a candidate for a bowel and bladder training program. R1's care plan dated 12/19/23 identified R1 required max assist with toilet use. The care plan did not address a R1's goals for incontinence, toileting program/schedule or other associated individualized interventions. R1's bowel and bladder program screener dated 1/5/24 identified R1 was a candidate for schedule toileting with a score of 13. R1 voided appropriately without incontinence, but less then daily. Was incontinent of stool one to three times a week. Required assist of one person to get to the bathroom, was forgetful but followed commands, and sometimes mentally aware of the need to toilet, and was a candidate for a bowel and bladder training program. In review of R1's record, although the bowel and bladder assessments identified R1 was a candidate for a bowel and bladder training program to improve or maintain function, the care plan did not identify R1's continence goals and individualized toileting needs based on the assessment. During interview on 1/12/24 at 8:32 a.m., nursing assistant (NA)-A indicated her shift typically started at 11:00 p.m. and R1 would typically be sleeping by the start of NA-A's shift. NA-A would know if R1 needed to go to the bathroom by checking R1's depend. NA-A rarely had to check R1's depend due to R1 not typically being	F 656	practitioner will continue to assist with weekly wound assessments and update treatments and diagnosis as needed. Director of Nursing and/or designee is responsible for compliance. Audits on MDS CAA area with appropriate care plan interventions and visual observation of the care plan interventions will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 02/09/2024	

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F 656	Continued From page 16	F 656		

incontinent. NA-A thought R1 used the toilet prior to the start of her shift. NA-A stated she did not recall seeing a urinal in R1's room.

During interview on 1/11/24 at 3:38 p.m., director of nursing (DON) explained she expected for staff to anticipate R1's needs for toileting, repositioning, comfort and activities of daily living. DON would expect staff to learn R1's preferences and schedules and anticipate based off what they have learned. If a resident was up in the middle of the night toileting should be offered. DON would expect visual checks on rounds at night and the rounding schedule is every two hours. DON was unaware if R1 could use the call light. Don was unaware of R1's toileting care plan.

R4's face sheet noted R4 was admitted to the facility on 12/31/23 with medical diagnoses that included severe protein-calorie malnutrition, adult failure to thrive, hypotension (low blood pressure), anemia (low amount of healthy red blood cells), and Wernicke's encephalopathy (a degenerative brain disorder related to lack of vitamin B). The admission Minimum Data Set (MDS) was not completed as R4 was still in the initial assessment period.

R4's Braden Scale for Predicting Pressure Sore Risk dated 12/31/23, was a score of 12 indicating R4 was at high risk for developing pressure sores.

R4's Functional Abilities and Goals Assessment dated 1/2/24, identified that R4 used a manual wheelchair and walker for mobility, needed moderate assist moving from lying to sitting to standing and transferring to/from chair or bed.

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F 656	Continued From page 17 R4's New Patient Progress Note by nurse practitioner-A (NP-A) dated 1/2/24, noted that R4 was admitted with a developing sacral pressure ulcer. R4's care plan included focuses on pressure ulcers and skin integrity initiated on 1/2/24 that were not completed. The pressure ulcer focus included "The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for ulcer development r/t [related to]." No goal or interventions were identified for R4's pressure ulcer. The focus on skin integrity indicated "The resident has potential/actual impairment to skin integrity" with goal identified to maintain or develop clean and intact skin by review date. Interventions included application of barrier cream after incontinent episodes, keep skin clean and dry, use lotion on dry skin. Incomplete interventions included use of unspecified medical equipment for protecting skin while in wheelchair and bed. The care plan did not address R4's known pressure ulcer on admission and did not address individualized interventions needed to maintain R4's skin integrity. R4's Integrated Wound Care initial consultation note by NP-B dated 1/2/24, identified a stage 1 pressure ulcer on R4's coccyx and further identified that R4 was incontinent of bowel and relied on staff for bed mobility and transfers. Treatments included offload reposition and turn R4 every 2 hours and as needed. It further specified that the plan of care was discussed with facility staff. R4's care plan did not contain revisions to include the direction to offload R4 every two hours and as needed. R4's Integrated Wound Care follow-up progress	F 656		

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F 656	Continued From page 18 note by NP-B dated 1/9/24, identified the coccyx pressure ulcer as stage 2. Treatment instructions continued to include offload, reposition, and turn R4 every 2 hours and as needed. The care plan did not include revisions to include the off-loading schedule direction from NP-B. During interview on 1/11/24 at 5:18 p.m., director of nursing (DON) stated treatment instructions from R4's Integrated Wound Care note from 1/2/24 included turning and repositioning. DON would expect the recommendation from the wound consult to be on the care plan, R4's care plan for skin does not recommend turning and repositioning, and turning and repositioning are standards of practice with pressure ulcers. DON stated the facility's responsibility with the treatment and prevention of pressure ulcers included ensuring interventions were in place, including care planning. R5's quarterly Minimum Data Set (MDS) assessment dated 12/12/23, indicates R5 was admitted to the facility on 8/4/23 with medical diagnoses including articular cartilage disorder of right hip (damage to the cartilage cushioning the hip joint), tendency to fall, weakness, intellectual disabilities, atherosclerosis (buildup of fatty plaques in arteries) polyosteoarthritis, anemia, heart failure, type 2 diabetes with hyperglycemia (elevated blood sugar levels), chronic obstructive pulmonary disease, and malnutrition. R5's Brief Interview for Mental Status (BIMS) score was 8, indicating moderate cognitive impairment. R5 utilized a walker and ambulated independently, was independent with mobility in bed and transfers from bed to chair, required moderate assistance with toileting, and required maximal assistance with bathing. R5 had a suprapubic	F 656		

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F 656	Continued From page 19 (indwelling) catheter and was occasionally incontinent of bowel. The care area assessment (CAA) for pressure ulcer/injury for R5, signed on 8/17/23, notes risk factors included pressure, incontinence, cognitive loss limiting mobility, use of opioid medications, diagnoses of diabetes and severe pulmonary disease, and other complicating factors included R5 being newly admitted. The CAA indicated identification of potential casual factors for impaired skin integrity, but the record did not include documentation of the implementation of corresponding interventions. R5's care plan focus for skin dated initiated on 8/4/23, and resolved on 9/7/23 noted resident has actual impairment to skin integrity. Interventions included apply barrier cream after each incontinent episode, keep skin clean and dry, use lotion on dry skin, resident needs pressure relieving cushion to protect skin while in wheelchair, and resident needs pressure relieving mattress and pillow to protect skin while in bed, all marked as resolved between 9/1/23 and 9/7/23. After 9/7/23, a focus on skin was no longer active/included on R5's care plan. An initial incident progress note by nursing dated 12/26/23, indicated R5 was assessed and found to have skin alteration on left foot between 3rd and 4th toes, area dark purple/black, reddened periwound area (skin surrounding a wound) extending to top of foot. An unidentified wound nurse practitioner (NP) assessed wound as an unstageable pressure ulcer (full severity of pressure wound cannot be determined because it is obscured by slough (wet light-colored dead tissue) and/or eschar (dry hard dark colored dead	F 656		

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F 656	Continued From page 20 tissue)) and recommended an antibiotic. Writer noted they will try to obtain less constricting shoes for R5. R5's Wound Evaluation report dated 12/26/23 by clinical manager-C (CM-C), notes wound #1 was an unstageable pressure wound located on left dorsum 3rd interdigital space (space between the 3rd and 4th toes on the top side of the left foot), wound was acquired in the facility 2 days prior. Treatment included wound care orders for cleanings and dressing and additional care included customized footwear. The care plan was not revised to address wound #1 which was identified as a pressure ulcer, on R5's left foot. Interventions to improve or stabilize R5's impaired skin integrity were not care planned. This precluded monitoring of effectiveness and subsequent updating of the care plan and interventions as appropriate. R5's Wound Evaluation report of wound #2 by unknown author dated 1/7/24, notes an undiagnosed type of wound that measured 0.56 cm² in area. The photo attached to the evaluation showed an open area on the bottom of the tip of the third toe on the left foot that extended through the outer layer of skin and was bright red without visible drainage surrounded by pale wet-appearing skin peeling off along the right edge of the wound. R5's care plan was not revised to identify the 2nd toe wound. This precluded monitoring of effectiveness and subsequent updating of the care plan and interventions as appropriate. At 11:33 a.m. on 1/10/24, a nursing progress note indicted on assessment R5's toe was 100%	F 656		

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F 656	Continued From page 21 necrotic and stiff with discoloration of foot in general, identified as a major change since last assessed and photographed on 1/7/24. Unidentified NP was updated on wound deterioration and orders given to send R5 to emergency department. R5 was transported to the hospital by emergency medical services. During an interview on 1/12/24 at 5:18 p.m., director of nursing (DON) stated R5 went to the hospital this week because he had a toe that started changing and he was sent out for evaluation. DON stated the Skin and Wound Evaluation of wound #1 dated 1/10/24 does not have all information completed but does identify an in-house acquired pressure ulcer on R5's left dorsum 3rd interdigital space. The wound wasn't present upon admission. DON stated R5's care plan for skin directs to keep skin clean and dry, use lotion on dry skin, and barrier cream after incontinence, but interventions for the toe are not on R5's care plan and care planning was not done for the wounds. If there is a new skin issue that is a pressure ulcer, the nurse would need to do a report, notify family and providers, request orders for treatment, and ensure interventions are in place such as medical equipment and supplies, care planning, and nutrition. Policy and procedure titled Care Plans, comprehensive person-centered dated 11/30/21, identified the purpose is to have measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. incorporate identified problem areas; h. incorporate risk factors associated with identified problems;	F 656		

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F 656	Continued From page 22 i. build on the resident's strengths; k. reflect treatment goals, timetables and objectives in measurable outcomes; l. identify the professional services that are responsible for each element of care; m. aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. reflect currently recognized standards of practice for problem areas and conditions. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 14. The interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met;	F 656		
F 684 SS=D	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	F 684		2/9/24

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F 684	Continued From page 23 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 comprehensively assess impaired skin integrity and initiate and evaluate appropriate interventions for 1 of 1 residents (R5) reviewed for non-pressure related skin injuries. Findings include: R5's quarterly Minimum Data Set (MDS) assessment dated 12/12/23, indicated R5 was admitted to the facility on 8/4/23 with medical diagnoses including articular cartilage disorder of right hip (damage to the cartilage cushioning the hip joint), tendency to fall, weakness, intellectual disabilities, atherosclerosis (buildup of fatty plaques in arteries) polyosteoarthritis, anemia, heart failure, type 2 diabetes with hyperglycemia (elevated blood sugar levels), chronic obstructive pulmonary disease, and malnutrition. R5's Brief Interview for Mental Status (BIMS) score was 8, indicating moderate cognitive impairment. R5 utilized a walker and ambulated independently, was independent with mobility in bed and transfers from bed to chair, required moderate assistance with toileting, and required maximal assistance with bathing. R5 had a suprapubic (indwelling) catheter and was occasionally incontinent of bowel. The care area assessment (CAA) for pressure ulcer/injury for R5, signed on 8/17/23, notes assessment was triggered by R5's need for extensive assistance with bed mobility and risk of	F 684	F 684 R 5 wound has been classified as a diabetic ulcer with subsequent amputation. R 5□s care plan for skin integrity and care plan interventions was re-activated on 1/17/2024. R 5 will have a skin audit completed, a new pain assessment, and a pressure injury care plan initiated, and interventions initiated. All R 5 wound assessments from 12/1/2023 until present will be reviewed, the skin and wound documentation updated to include diabetic ulcer wound classification and a comprehensive skin assessment including progress note addressing all inconsistencies will be documented. All current residents who have non-pressure injuries, their skin and care plan were reviewed and updated as needed. Future residents who admit with non-pressure injuries will have a visual skin assessment, a skin risk assessment completed, and care plan focus, goal and interventions initiated with weekly observation and documentation until healed. Facility Nursing Staff will be in-serviced on the Pressure Risk Injury Risk Assessment Policy with emphasis on item 4c that if a new pressure injury is noted, complete a new skin assessment and on item #5 to develop a care plan with interventions and to update the care plan intervention if the	

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F 684	Continued From page 24 developing pressure ulcers. Notes a potential and not actual problem was present. Risk factors included pressure, incontinence, cognitive loss limiting mobility, use of opioid medications, diagnoses of diabetes and severe pulmonary disease, and other complicating factors included R5 being newly admitted. The CAA indicated identification of potential casual factors for impaired skin integrity, but the record did not include documentation of the implementation of corresponding interventions. R5's care plan focus for skin dated initiated on 8/4/23, and resolved on 9/7/23 noted resident has actual impairment to skin integrity. Interventions included apply barrier cream after each incontinent episode, keep skin clean and dry, use lotion on dry skin, resident needs pressure relieving cushion to protect skin while in wheelchair, and resident needs pressure relieving mattress and pillow to protect skin while in bed, all marked as resolved between 9/1/23 and 9/7/23. After 9/7/23, a focus on skin was no longer active/included on R5's care plan. R5's provider progress note by medical doctor-A (MD-A) dated 10/19/23, does not indicate any concerns regarding R5's skin or impairments in skin integrity. R5's Braden Scale for Predicting Pressure Sore Risk dated 12/12/23, noted a total score of 21 indicating R5 was not at risk of developing pressure sores. An initial incident progress note by nursing dated 12/26/23, indicated writer noted resident limping, expressing pain, and removing left shoe when sitting. R5 was assessed and found to have skin	F 684	resident condition changes and/or if care plan interventions are deemed inadequate and following the care plan. Clinical managers reviewed the skin and wound app functions and features and reviewed the pressure ulcer staging visual pocket reference. The wound Nurse Practitioner along with the physician nurse practitioner will continue to assist with weekly wound assessments and update treatments and diagnosis as needed. Director of Nursing and/or designee is responsible for compliance. Audits on non-pressure injury care plans with appropriate care plan interventions initiated will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 02/09/2024	

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F 684	Continued From page 25 alteration on left foot between 3rd and 4th toes, area dark purple/black, reddened periwound area (skin surrounding a wound) extending to top of foot. An unidentified wound nurse practitioner (NP) assessed wound as an unstageable pressure ulcer (full severity of pressure wound cannot be determined because it is obscured by slough (wet light-colored dead tissue) and/or eschar (dry hard dark colored dead tissue)) and recommended an antibiotic. Unidentified NP was updated and ordered an antibiotic. Writer noted they will try to obtain less constricting shoes for R5. R5's Wound Evaluation report dated 12/26/23 by clinical manager-C (CM-C), notes wound #1 was an unstageable pressure wound located on left dorsum 3rd interdigital space (space between the 3rd and 4th toes on the top side of the left foot), wound was acquired in the facility 2 days ago, measured 0.17 centimeters squared (cm^2) in area, 0.55 cm in length, and 0.42 cm in width. The wound bed consisting of 100% eschar, the wound edges attached and periwound skin red, pain level continuous 6 out of 10. Treatment was cleansing with Vashe (an antimicrobial cleansing solution), application of Santyl (an ointment that helps break up dead tissue) then calcium alginate (substance that promotes wound healing), and covering with a foam-bordered adhesive silicone pad dressing. Additional care included customized footwear. The care plan was not revised to address wound #1 which was identified as a pressure ulcer, on R5's left foot. Interventions to improve or stabilize R5's impaired skin integrity were not care planned. This precluded monitoring of effectiveness and subsequent updating of the	F 684		

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F 684	Continued From page 26 care plan and interventions as appropriate. A wound care order for R5 started 12/27/23, and discontinued at unknown date instructed wound treatment to left foot 3rd toe daily and as needed: cleanse with Vashe and let moistened gauze remain on wound bed for three minutes, apply skin prep to periwound area, place Santyl on wound bed followed by calcium alginate, cover with bordered foam dressing cut in half. R5's provider progress note by MD-A dated 12/28/23, noted that R5 continued to have blood glucose (blood sugar) readings in the 400's (high blood sugar levels) due to type 2 diabetes. Physical exam noted the middle toe on the left foot was tender and bandaged and R5 complained of left foot pain. A nursing progress note dated 12/28/23, indicated R5 experienced moderate pain associated with unstageable pressure ulcer to left foot dorsum 3rd interdigital space. R5 unable to wear his tennis shoes and ambulating with non-slipper socks, obvious limp with ambulation, and expression of pain. Noted concern with the infection as redness had extended further up the foot and the toes were purple-red. Unidentified NP was updated and advised resident see podiatrist for further evaluation. R5's provider progress note from NP-A dated 12/29/23, indicated new diagnosis of cellulitis (skin infection) of the left lower extremity with development of a blister on the top of the big toe and second toe on the left foot. Noted to probably be from R5's shoes. One area was blistered with surrounding reddened skin and another blister burst. Foot warm to touch and swollen. Antibiotics	F 684		

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F 684	Continued From page 27 were prescribed and consult to vascular surgery planned. Noted that R5 has uncontrolled diabetes and thus an antibiotic was started when the cellulitis on left foot became red and swollen. An appointment with vascular surgery was made. Physical exam notes middle toe on left foot is tender and bandaged and R5 complained of left foot pain. A nursing progress note dated 1/2/24, indicated R5 completed a podiatry appointment and podiatrist identified wound as a Wagner grade 2 ulcer (a type of ulcer related to complications of diabetes) with cellulitis and fibrous and necrotic tissue and recommended vascular testing. Podiatry consult notes by MD-C from previous podiatry appointments on 9/5/23, 9/19/23, 11/7/23, and 12/12/23 all documented the appointments did not occur due to R5 being absent or not in their room. R5's provider progress note from NP-A dated 1/5/24, indicated R5 continued to complain of left foot pain and the antibiotic for left foot cellulitis was changed. A subsequent order placed 1/3/24 and discontinued at an unknown date instructed wound treatment to left 3rd toe Wagner grade 2 ulcer daily: cleanse with Vashe and leave moistened gauze on wound bed for three minutes, paint wound with betadine and cover with Medipore pad (soft cloth adhesive dressing). R5's Wound Evaluation report of wound #1 by unknown author dated 1/7/24, notes an unstageable pressure wound of left dorsum 3rd interdigital space of unknown age and notes the wound remained unstageable and increased in size from evaluation on 12/26/23 to 4.55 cm² in area, 3.19 cm in length, and 2.33 cm in width and	F 684		

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F 684	Continued From page 28 was slow to heal and deteriorating. R5's Wound Evaluation report of wound #2 by unknown author dated 1/7/24, notes an undiagnosed type of wound. Wound location, age, and place of acquisition were not identified. The wound measured 0.56 cm² in area, 1.21 cm in length, and 0.63 cm in width. No further assessment or details about the wound were documented. The photo attached to the evaluation showed an open area on the bottom of the tip of the third toe on the left foot that extended through the outer layer of skin and was bright red without visible drainage surrounded by pale wet-appearing skin peeling off along the right edge of the wound. R5's provider progress note from NP-A dated 1/8/24, noted R5 seen for fatigue, fall, and worsening of left foot wound. Indicates podiatry was consulted and changed R5's antibiotic at visit on 1/5/24. Second toe looks purple-ish and since wound appears worsened vascular surgery to be consulted instead of podiatry. Physical exam notes middle toe on left foot is tender, bandaged and R5 complained of left foot pain. R5's care plan was not revised to identify the 2nd toe wound. This precluded monitoring of effectiveness and subsequent updating of the care plan and interventions as appropriate. R5's provider progress note from NP-A dated 1/9/24, noted R5 is waiting for a vascular surgery appointment to be scheduled. Notes middle toe on left foot is tender and bandaged and R5 complained of pain in left foot. A nursing progress noted dated 1/9/24 at 10:46	F 684		

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F 684	Continued From page 29	F 684		

p.m., indicated R5 removed their specialized shoe, sock, and dressing from his left foot because it was hurting. R5 was given a dose of as needed Oxycodone (an opioid painkiller).

A nursing progress note dated 1/10/23 at 5:58 a.m., noted R5 woke at 5:00 a.m. complaining of lower extremity pain and was given a dose of as needed dose Oxycodone.

R5's Wound Evaluation report of wound #1 by unknown author dated 1/10/24 at 10:30 a.m., identified an unstageable pressure wound of left dorsum 3rd interdigital space notes the wound was unstageable due to slough and/or eschar, was acquired in the facility, and measured 3.4 cm^2 in area, 2.91 cm in length, and 1.37 cm in width. The wound was identified as slow to heal and deteriorating. Further assessment of the wound was not documented. In the photo attached to the evaluation the 3rd toe on the left foot's top side was shiny deep purple/black and appeared hard from base to toenail, extending up the sides next to the toenail but not to the tip of the toe above the nail. The tip of the toe appeared moist and pale purple and the toenail was deep purple/black. There was an additional wound visible on the big toe toenail at the outer edge extending approximately one third of both the length and width of the toenail. The nail appeared to be missing with the underlying tissue visible and dark purple/black.

The Wound Evaluation report of wound #2 by unknown author dated 1/10/24 at 10:30 a.m., identified an undiagnosed type of wound. Wound location, age, and place of acquisition were not identified. The wound measured 1.16 cm^2 in area, 1.51 cm in length, and 1.11 cm in width. No

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F 684	Continued From page 30 further assessment or details about the wound were documented. The photo attached to the evaluation showed the bottom of the left foot with the previous open area on the third toe now dark purple and extended further in length and width with no exudate (drainage). The tip of the toe around the wound remained a pale white color and yellow calloused flaky skin was scattered across the ball of the foot and the second and fifth toes. A Skin and Wound Evaluation of an unknown wound by unknown author dated 1/10/24 at 11:30 a.m., noted an unidentified wound and does not identify the type of wound, the location, how it was acquired, how long it has been present, evidence of infection, the condition of the wound bed, exudate, condition of periwound area, wound pain, or treatment. The wound was noted to be deteriorating and measured 1.2 cm² in area, 1.5 cm long, and 1.1 cm wide. A Skin and Wound Evaluation of wound #1 by unknown author dated 1/10/24 at 11:30 a.m., identified a slow to heal deteriorating pressure ulcer on the left dorsum 3rd interdigital space that is unstageable due to slough and/or eschar and was acquired at the facility and measured 3.4 cm² in area, 2.9 cm long, and 1.4 cm wide. The age of the wound, condition of wound bed, exudate, condition of periwound area, wound pain, or treatment were not documented. The facility did not provide any other assessments. At 11:33 a.m. on 1/10/24, a nursing progress note documented R5 continued to complain and the third toe on the left foot was more painful than	F 684		

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F 684	Continued From page 31 usual. Note indicated that on assessment, nursing noted the toe to be 100% necrotic and stiff with discoloration of foot in general, identified as a major change since last assessed and photographed on 1/7/24. Indicates writer has been trying to get R5 an appointment with vascular surgery since 1/8/24 but the soonest appointment available was 1/15/24. Unidentified NP was updated on wound deterioration and orders given to send R5 to emergency department. R5 was transported to the hospital by emergency medical services. During an interview on 1/12/24 at 5:18 p.m., director of nursing (DON) stated R5 went to the hospital this week because he had a toe that started changing and he was sent out for evaluation. The provider had ordered for him to see a specialist and we couldn't arrange it in time for him to see the vascular specialist, so we sent him out. DON stated the Skin and Wound Evaluation of wound #1 dated 1/10/24 does not have all information completed but does identify an in-house acquired pressure ulcer on R5's left dorsum 3rd interdigital space. The wound wasn't present upon admission. DON stated R5's care plan for skin directs to keep skin clean and dry, use lotion on dry skin, and barrier cream after incontinence, but interventions for the toe are not on R5's care plan. DON stated their expectations for documentation of the wound were not met, communication for handling and treating the wound across disciplines was not appropriate, and care planning was not done for the wounds. It is the facility's responsibility to assess the risk of potential pressure ulcers, to prevent them from occurring, and to treat them if they do. If there is a new skin issue, the nurse would be notified and would evaluate the wound. If it is a pressure	F 684		

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F 684	Continued From page 32	F 684		

ulcer, they would need to do a report, notify family and providers, request orders for treatment, and ensure interventions are in place such as medical equipment and supplies, care planning, and nutrition.

NP-A was called on 1/12/24 at 5:54 p.m. and a message was left, however no return phone call was received.

Facility policy titled Care Plans, Comprehensive Person-Centered dated 11/30/21, included the following:

8. The comprehensive, person-centered care plan will:
a.) include measurable objectives and timeframes; b.) describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c.) describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; d.) describe any specialized services to be provided as a result of PASARR recommendations; e.) include the resident's stated goals upon admission and desired outcomes; f.) include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g.) incorporate identified problem areas; h.) incorporate risk factors associated with identified problems; i.) build on the resident's strengths; j.) reflect the resident's expressed wishes regarding care and treatment goals; k.) reflect treatment goals, timetables and objectives

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F 684	Continued From page 33 in measurable outcomes; l.) identify the professional services that are responsible for each element of care; m.) aid in preventing or reducing decline in the resident's functional status and/or functional levels; n.) enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o.) reflect currently recognized standards of practice for problem areas and conditions. 9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a.) No single discipline can manage an approach in isolation. b.) The resident's physician (or primary healthcare provider) is integral to this process. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. a.) When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. b.) Care planning individual symptoms in isolation may have little, if any, benefit for the resident. 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).	F 684		

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F 684	Continued From page 34 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to perform comprehensive skin assessments and provide interventions for pressure ulcer prevention and treatment for 2 of 3 residents (R4, R1) reviewed for pressure ulcers. Findings include R4's face sheet noted medical diagnoses that included severe protein-calorie malnutrition, adult failure to thrive, hypotension (low blood pressure), anemia (low amount of healthy red blood cells), and Wernicke's encephalopathy (a degenerative brain disorder related to lack of vitamin B).	F 686	F 686 R 4 will have a risk management incident completed and root cause identified, a visual skin assessment completed and documented, a new Braden Assessment and completion of the pressure injury care plan. All current and future residents admitted with pressure injuries will have a skin assessment completed along with care plan focus created and interventions initiated per facility policy. Facility Nursing Staff will be in-serviced on the Pressure Risk Injury Risk Assessment Policy with emphasis on item 4c that if a new pressure injury is noted, complete a new skin assessment and on item #5 to	2/9/24

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F 686	Continued From page 35 R4's face sheet identified R4 was admitted to the facility on 12/31/23. The admission Minimum Data Set (MDS) was not completed as R4 was still in the initial assessment period. R4's Braden Scale for Predicting Pressure Sore Risk dated 12/31/23, was a score of 12 indicating R4 was at high risk for developing pressure sores. A provider order placed 12/31/23 indicated staff were to monitor R4's sacral dressing every shift and consult the as needed order to replace the dressing if missing or soiled. R4's Skin Audit progress note upon admission dated 12/31/23, identified redness on R4's tailbone with Mepilex dressing intact upon admission. R4's care plan included focuses on pressure ulcers and skin integrity initiated on 1/2/24 that were not completed. The pressure ulcer focus included "The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for ulcer development r/t [related to]" and the focus on skin integrity indicated "The resident has potential/actual impairment to skin integrity." No goal or interventions were identified for R4's pressure ulcer. The goal identified for R4's skin was to maintain or develop clean and intact skin by the review date. Individualized interventions included may apply barrier cream after each incontinent episode, keep skin clean and dry, use lotion on dry skin. Incomplete interventions included "The resident needs (SPECIFY: pressure relieving/reducing cushion, pillows, sheepskin padding etc.) to protect the skin while in wheelchair" and "The resident needs	F 686	develop a care plan with interventions and to update the care plan intervention if the resident condition changes and/or if care plan interventions are deemed inadequate and following the care plan. Clinical managers reviewed the skin and wound app functions and features and reviewed the pressure ulcer staging visual pocket reference and competency performed. Director of Nursing and/or designee is responsible for compliance. Audits on completion of the weekly skin and wound assessment, visual audit of wounds and pressure injury care plan completion will begin weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 02/09/2024	

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F 686	Continued From page 36 (SPECIFY: pressure relieving/reducing mattress, pillows, sheepskin padding etc.) to protect the skin while IN BED." R4's Functional Abilities and Goals Assessment dated 1/2/24, identified that R4 used a manual wheelchair and walker for mobility, needed moderate assist moving from lying to sitting to standing and transferring to/from chair or bed. R4's New Patient Progress Note by nurse practitioner-A (NP-A) dated 1/2/24, noted that R4 was admitted with a developing pressure ulcer and included a plan for a wound team consult. The physical examination of R4's skin indicated NP-A had not seen the sacral side of R4 but noted in the chart that R4 had a developing pressure ulcer. R4's Integrated Wound Care initial consultation note by NP-B dated 1/2/24, identified a stage 1 pressure ulcer on R4's coccyx measuring 2.2 centimeters squared (cm^2) in area and further identified that R4 was incontinent of bowel and relied on staff for bed mobility and transfers. Treatments included offload reposition and turn R4 every 2 hours and as needed. It further specified that the plan of care was discussed with facility staff. It was not evident the care plan was revised to include the direction to offload R4 every two hours and as needed. R4's Wound Evaluation dated 1/2/24 by CM-B noted a stage 2 pressure ulcer (partial-thickness skin loss with exposed dermis) on the coccyx measuring 1.64 cm^2 in area. In review of R2's record, it did not identify and/or account for the differences between NP-B's determination of stage 1 ulcer measuring 2.2 cm^2 and CM-B's	F 686		

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F 686	Continued From page 37 determination of stage 2 ulcer measuring 1.64 cm² completed on the same day. R4's Integrated Wound Care follow-up progress note by NP-B dated 1/9/24, identified the coccyx pressure ulcer as stage 2 measuring 11.76 cm² in area, 4.9 cm long, and 2.4 cm wide with scant serosanguinous (blood-tinged watery) exudate (drainage), epithelial wound tissue (pink skin with thin layer of new skin), and normal periwound skin (skin surrounding the wound) with stalled healing progress. Treatment instructions included apply Hydrogel and cover the wound with foam (a silicone and foam pad dressing, brand name Mepilex) and change the dressing daily and as needed. Instructions continued to include offload, reposition, and turn R4 every 2 hours and as needed. The plan of care was discussed with facility staff. It was not evident the care plan was revised to include the off-loading schedule. R4's Wound Evaluation dated 1/9/24, by unknown author noted a healable (healing is not slow, stalled, or unachievable) stage 2 pressure ulcer measuring 8.2 cm² in area, 4.9 cm long, and 2.4 cm wide. Further information including description of the wound bed, signs of infection, exudate, periwound area, wound pain, treatment (cleansing, dressing, and additional cares such as turning and repositioning), and wound progress were not completed. In review of R4's record, it did not identify and/or account for the differences between NP-B's wound measurement of an 11.76 cm² wound with stalled progress and the unknown author's measurement of an 8.2 cm² wound that was healable completed on the same day. During observation on 1/12/2024 at 2:13 p.m., R4	F 686		

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F 686	Continued From page 38 was supine (lying face up) in bed. RN-D assisted R4 with rolling to one side, lowered R4's pants, and observed the coccyx pressure ulcer. The wound was shiny and red with a small approximately 1.3 cm long open slit in the skin to the right of the gluteal cleft with redness extending into R4's perineal area into skin folds at the top of the inner leg and onto genitalia. There was no dressing (Mepilex) present on R4 or visible in R4's clothing or bedding. RN-D stated there was no dressing present. Record review revealed no documentation of a reason for the absence of the dressing, such as the dressing falling off or becoming dirty during cares. R4's treatment administration record for 1/12/24 documented that the dressing had been monitored by the overnight shift and the day shift nursing staff and did not indicate use of the as needed order to replace if missing or soiled. During an interview on 1/12/24 at 2:30 p.m., CM-A stated that there was no dressing present when they entered R4's room during the wound inspection with additional wound care supplies. Wound care orders were not followed because there was no Mepilex on, the dressing was missing, and the current orders say R4 should have a Mepilex on the pressure ulcer. During interview on 1/11/24 at 5:18 p.m., director of nursing (DON) stated the expectation is nursing staff follow wound care orders, dressings should be in place unless a reason why it was removed has been documented, communicated, and dressing replaced. DON identified treatment instructions from R4's Integrated Wound Care note from 1/2/24 included turning and repositioning. DON would expect the	F 686		

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F 686	Continued From page 39 recommendation from the wound consult to be on the care plan, R4's care plan for skin does not recommend turning and repositioning, and turning and repositioning are standards of practice with pressure ulcers. DON stated the facility's responsibility with pressure ulcers is to assess the risk for pressure ulcers, prevent new pressure ulcers, and treat existing pressure ulcers. DON stated that the facility would ensure interventions were in place including care planning and the resident would be referred to the wound team so that the wound certified NP would see and evaluate them on a weekly basis. R1's face sheet identified R1 was admitted to the facility on 12/19/23 and had diagnoses that included anoxic brain damage (a brain injury from lack of oxygen), type 2 diabetes, cataract, heart arrhythmias, gout, dry skin, and repeated falls. R1's admission MDS dated 12/23/23, included a staff assessment for mental status which indicated R1 had memory problems with both short- and long-term memory, was not oriented to current season/location/or staff, and had moderately impaired cognitive skills for daily decision making. R1 utilized a wheelchair and required moderate assistance with rolling side to side, maximal assistance with toileting hygiene and transfers to/from toilet, and was dependent on staff for transfers between bed and chair. R1's Nurse Admission/Readmission assessment dated 12/19/23, noted a stage 1 (intact skin with non-blanchable redness) right buttock pressure injury and stage 1 left buttock pressure injury with no further description or information. Also identified R1 was incontinent of bowel and bladder.	F 686		

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F 686	Continued From page 40 R1's care plan included focuses on pressure ulcers and skin integrity. The pressure ulcer focus initiated on 12/19/23 included the resident is potential [risk, sic] for pressure ulcer development related to fragile thin skin. No goals or interventions related to pressure ulcers were included on the care plan. The skin focus noted the resident has potential/actual impairment to skin integrity, initiated 12/19/23 with goal to maintain or develop clean and intact skin by the review date. Interventions, all initiated on 12/19/23, included application of barrier cream after incontinent episodes, keep skin clean and dry, use lotion on dry skin, the resident needs pressure reducing cushion to protect the skin while in wheelchair, and the resident needs pressure reducing mattress to protect the skin while in bed. R1's Care Area Assessment dated 12/30/23 for pressure ulcer/injury identified R1 had a stage 1 bilateral buttocks pressure ulcer. Analysis of findings section noted to assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin. Corresponding assessment data was not evident in R1's record. Risk factors identified included pressure, delirium limits mobility, cognitive loss limits mobility, and incontinence. Diagnoses presenting complications or increasing risk for pressure ulcer/injury identified were delirium and malnutrition. Other factors causing complication or increasing risk included devices that can cause pressure. R1's record did not identify the devices that increased the risk. There were no updates to R1's care plan evident after completion of the Care Area Assessment. The care plan did not comprehensively address R1's actual and	F 686		

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F 686	Continued From page 41 potential impairment of skin integrity. In review of R1's record it did not have a comprehensive pressure ulcer assessment that identified pressure points for turning and reposition needs, size, depth, wound bed characteristics, drainage and pain. Further not evident the stage 1 ulcers were being treated and continuously monitored for improvement or deterioration after identified upon admission. Vulnerable adult maltreatment report submitted to the State Agency dated 1/8/24, identified R1 was discharged from the hospital on 12/19/23 and admitted to facility's transitional care unit. R1 was readmitted to the hospital on 1/6/24 with a pressure injury to the coccyx. The report did not identify the measurements of the ulcer. The facility's policy titled Care Plans, Comprehensive Person-Centered last reviewed 11/30/21 included: The comprehensive, person-centered care plan will: - incorporate identified problem areas - incorporate risk factors associated with identified problems - aid in preventing or reducing decline in the resident's functional status and/or functional level - reflect currently recognized standards of practice for problem areas and conditions Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not	F 686		

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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 686	Continued From page 42 just addressing only symptoms or triggers.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess fall risk and implement appropriate fall interventions to decrease the risk for 2 of 3 residents (R1, R2) with falls. This resulted in harm for R1 who sustained two serious head injuries, was transferred to the hospital, and later died as a result of his injuries. Findings include: Vulnerable adult maltreatment report submitted to the State Agency dated 1/8/24, identified R1 was discharged from hospital on 12/19/23 and admitted to transitional care unit (TCU). R1 was readmitted to hospital on 1/6/24 . R1 was diagnosed with subdural hematoma, subarachnoid hemorrhage, parietal skull fracture, deep tissue injury to left heel, pressure injury to the coccyx. None of these conditions were present at the time of discharge from the hospital on 12/19/23. R1's Face Sheet undated, identified R1 had	F 689	F 689 R1 has since passed away. All fall incidents from survey exit until present will be reviewed and thoroughly investigated for root cause and fall care plan interventions updated. Future resident injuries that require hospitalization, a risk management incident will be completed, and a thorough investigation initiated along with a reportable incident will be initiated to the state agency per facility policy. Licensed Nurses and Social Workers will be in-serviced on the Facility Responsibilities for Reporting Abuse Tool with emphasis on the entire tool for what to report to the state agency. The IDT team will be in-serviced on the Abuse Reporting and Investigation policy with emphasis on reporting to the state agency serious bodily injuries and notification to the local authorities. The clinical managers will review the assessment scoring categories from the fall screener	2/9/24

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	245189	A. BUILDING _____ B. WING _____	C 01/12/2024

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F 689	Continued From page 43 diagnoses that included anoxic brain damage (lack of oxygen to the brain), nuclear cataract (excessive yellowing center of eye), unspecified hearing loss in the left ear, repeated falls, syncope (dizziness) and collapse (fall or give away). R1's fall risk assessment dated 12/19/23 identified R1 was a high fall risk with a score of 11, and had one to two falls in the last three months. R1 was chair bound and required assistance with elimination. Evaluation of R1's gait was not performed, and R1 was on medications that caused lethargy or confusion. R1 had predisposing diseases that impacted his fall risk. R1's admission assessment 12/19/23, identified R1 had a fall in the last month prior to admission to the facility. R1 was transferred from home to the hospital on 12/12/23 for an evaluation following a fall with syncope. Further identified, R1 was a Cantonese speaker and required the use of an interpreter. R1 had moderate difficulty with ability to hear, and no hearing aids or appliances were normally used. R1's family member (FM)-A was available and helped with admission assessment and anytime they needed to interpret tasks for R1. FM-A informed facility staff resident was hard of hearing and an IPad interpretation may not help. R1's bowel and bladder program screener dated 12/19/23, indicated R1 required assistance of one person to get to the bathroom, was alert and oriented, and sometimes mentally aware of the need to toilet. The screener identified R1 was a candidate for a bowel and bladder training program. There was no indication a bowel and	F 689	to proactively implement fall interventions to prevent resident injury along with information from the Care Area Assessment to assist with development a personalized care plan focus, goals, and interventions to prevent resident falls and following the care plan. Director of Nursing and/or designee is responsible for compliance. Audits on identifying fall intervention and initiation of interventions, care plan review and update of interventions, reporting of incidents to the state agency 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 02/09/2024	

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F 689	Continued From page 44 bladder program had been initiated. R1's care plan dated 12/21/23 identified R1 was at a high risk for falls due to a history of recent falls. The care plan directed staff to anticipate and meet needs, ensure the call light was in reach, and encourage resident to use call light as needed. R1 required prompt response to all requests for assistance. Physical therapy was to evaluate and treat as ordered or as needed, and R1 required assist of one with a front wheeled walker for transfers. The care plan did not identify a toileting schedule and/or a positioning schedule. R1's initial Minimum Data Set (MDS) dated 12/25/23, identified R1's preferred language of Chinese, and R1 needed or wanted an interpreter to communicate with a doctor or health care staff. Brief interview for mental status (BIMS, to assess cognition) was not completed. R1's assessment for lying to sitting on the side of the bed and ability to sit to stand were not applicable and not attempted. R1's chair to bed transfer required dependent assist and toilet transfer required substantial to maximum assist. R1 required substantial to maximum assist for toileting. R1 had not had a trial of a toileting program and R1 was frequently incontinent of bladder and always incontinent of bowel. A toileting program was not being implemented to manage continence. R1's fall Care Area Assessment (CAA) with an assessment reference date of 12/25/23, indicated R1 had an actual fall in the last month prior to admission. However, R1's history of falling and physical performance limitations were not complete. Medications included diuretics and internal risk factors of circulatory/heart (cardiac dysrhythmias) neuromuscular/functional	F 689		

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F 689	Continued From page 45 (incontinence and traumatic brain injury) perceptual (hearing impairment) orthopedic (arthritis) psychiatric (cognitive impairment). The care plan was not completed or identified any goals or overall objectives as a result of the CAA. R1's fall risk dated 1/5/24 identified R1 was a high fall risk with a score of 13. R1 had no falls in the past three months, was ambulatory and incontinent. R1 had balance problems with standing and walking, decreased muscular coordination, and required use of an assistive device. R1's incident report dated 1/6/24, indicated R1 had an unwitnessed fall and was found lying on the floor at 5:30 a.m. He was on his right side at the back of his room door. R1 hit the back of his head and had a laceration approximately size of a dime. R1 was shivering with a blanket partially covering his body and was unable to explain what occurred due to not speaking English. Nursing assistant reported the last time she checked on resident, he was sleeping soundly in bed. Immediate action taken was physical assessment, and vitals signs (blood pressure 115/45, pulse 88, tempature 97.3 and respirations 18).Was unable to complete pain assessment and R1 was assisted back to bed with the use of a Hoyer lift (full body mechanical lift) by two nursing staff. Level of pain rated at a score of three with facial expressions being sad, frightened, frowned body language tensed, distressed pacing, conceivability distracted or reassured by voice or touch. There were no predisposing environmental factors, physiological factors. Predisposing situation factors included using walker, call light within reach, ambulating without assist. Corresponding note dated 1/8/24,	F 689		

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F 689	Continued From page 46	F 689		

indicated interdisciplinary team (IDT) review of fall; patient last observed less then 60 minutes prior to fall or roll out of bed. Care plan followed. Patient did have a history of laying very close to the side of bed. Will look at and change care plan when R1 returns from emergency room and can get input from FM-A.

R1's medical record from 1/5/24 to 1/6/24 between 11:00 p.m. and 5:30 a.m., had no documentation R1 was provided with any cares and/or was toileted.

During interview on 1/10/24 at 10:55 a.m., (FM)-A indicated R1 resided with him prior to being admitted to the TCU. R1 had three falls while at home and the first fall happened due to R1 trying to get out of bed on his own and reported needing to go to the bathroom. The second fall happened while going down stairs, and the third fall happened attempting to get to the bathroom on his own. FM-A indicated R1 had the desire to go to the bathroom frequently and would attempt to go on his own. FM-A was notified of the fall on 1/6/24 and asked why R1 was on the floor. When FM-A arrived at the hospital R1 informed him he was trying to go to the bathroom.

During interview on 1/10/24 at 1:33 p.m., licensed practical nurse (LPN)-A identified she was R1's nurse the night of the fall. The last time she was in R1's room was to give intravenous therapy (IV) medications (fluids) at around 12:30 a.m. LPN-A reported R1 was COVID positive and R1's bedroom door had been closed. Around 5:30 a.m. LPN-A went to check on R1 and attempted to open the door a few times but noted resistance. LPN-A was able to gain visual entrance to the room and saw R1's head against

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F 689	Continued From page 47 the backside of the door causing the resistance. R1 was laying on the floor and had a blood smear and a laceration (cut) on the back of his head. R1 was breathing fast and shaking. LPN-A noted blood smears and drops of blood around the bathroom and entrance to the room. LPN-A indicated it was as if R1 was coming out of the bathroom had fallen. He was positioned between the room entrance and bathroom entrance. LPN-A left R1 unattended to go get assistance from nursing assistant (NA)-A and asked when NA-A last provided cares and timing however, timing reports were inconsistent. LPN-A explained NA-A reported to her she did not toilet R1 on the last check because he was sleeping and R1 was supposed to use his call light. Then NA-A went back to assist R1 and LPN-A called nurse practitioner (NP), 911, and the nurse manager. LPN-A reported it was an unwitnessed fall with a head strike and R1 was on anticoagulation. LPN-A went back into the room to complete vitals and assessment. During interview on 1/11/24 at 2:30 p.m., LPN-B indicated she helped LPN-A with R1 the night of the fall with the IV around 12:30 a.m. R1 was awake at 12:30 p.m. and was in bed the whole time during the interaction. The second time LPN-B was in the room was after R1 had fallen and was already transferred back into bed. LPN-B indicated LPN-A had not called 9-1-1 at that time so instructed for LPN-A to call 9-1-1, NP and family. During interview on 1/10/24 at 3:52 p.m., nursing assistant (NA)-A indicated LPN-A had left R1 to find her to notify her of the fall. NA-A entered the room alone and visualized R1's head against the door to enter R1's room. R1 had dried blood	F 689		

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F 689	Continued From page 48 matted in his hair, dried blood on both hands, dried blood spots of blood on the floor, and dried blood on the door of the bathroom. NA-A indicated it looked as though R1 was coming out of the bathroom himself and fell hitting his head on the bathroom door. R1 had gotten a blanket somehow because it was over him. R1 was only in a hospital gown and shivering, he said he was cold. NA-A transferred R1 from the floor to a standing position with the use of a transfer belt and walked him with a walker from the entrance of the room to his bed. R1 was sitting on the edge of the bed while NA-A cleaned all the blood off of him and changed his gown to get him ready to go to the hospital. NA-A was unaware of the last time R1 was toileted but thought R1 had gotten up to go use the bathroom alone and fell. NA-A stated the director of nursing,clinical manager or administrator had not asked any questions about the event since the date of the fall. NA-A indicated even though the blood that was in R1's hair, on the floor, and on the bathroom door was dried, she did not think R1 was not on the floor too long because she had just been in the room between 4:00 a.m. to 4:30 a.m. During an interview on 1/11/24 at 3:59 p.m., clinical manager (CM)-A indicated R1 was expected to use his call light, but only used it very very few times because R1 did not really understand. CM-A could not confidently say if R1 knew how to use the call light. Staff were suppose to check on R1 frequently and anticipate basic needs such as food and toileting due to communication barriers. It was expected staff are anticipating needs visually and should be checking during rounds no longer than an hour to confirm resident safety and avoid accidents such as falls . If residents are up in the middle of the	F 689		

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F 689	Continued From page 49 night it was the expectation staff would offer toileting. Staff were to be visually checking residents on walking rounds if the door was closed. R1's door was kept open until testing positive for COVID on 1/4/24, then R1 was on isolation and his door was kept closed. During interview on 1/10/24 at 3:29 p.m., the director of nursing (DON) indicated the expectation with falls with head strikes include a head to toe physical assessment, neurological examination, and pain assessment to be completed. Moving a resident following a fall with a head strike would depend on the findings of the assessment. DON indicated it would be good nursing practice for the nurse to stay with the resident upon moving a resident following a fall with a head strike. DON was aware of a fall and was notified the next day on 1/7/24 at 11:27 a.m. by the day shift charge nurse. The investigation involved asking if the care plan was followed at the time of the fall, the last known "well time," and if there was anything suspicious regarding the fall. DON indicated R1's last known well time was approximately 4:30 a.m., an hour before the fall and the nursing assistant who was involved was nursing assistant (NA)-B, however did not have time to confirm if that was accurate. DON was unaware of the last time R1 was toileted as it was not documented. DON did not identify anything suspicious regarding the event of the fall. DON indicated the facility handled the fall and everything was completed appropriately with no concerns following proper protocol and the care plan was followed. DON indicated R1 had a history of falling very close to his bed prior to admission and the causal analysis was R1 rolled out of bed and crawled to the door. DON did not complete any interviews with nurses or nursing	F 689		

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F 689	Continued From page 50 assistants that were present at the time of the fall. During a subsequent interview on 1/11/24 at 11:14 a.m., DON and administrator both indicated they had not reviewed the facility's video footage as part of the fall investigation. DON stated she did not report the fall with major injury because the care plan was being followed. DON ascertained that information through the investigation that consisted of interviewing dayshift charge nurse (RN-A) and the incident report. According to her interview and the documentation of the event, the nursing assistant had reported checking on him an hour before the fall occurred. DON stated she checked the NA charting, however the time documented of that check, was completed after R1 left the facility. DON did not interview any other staff members including the staff that had worked when the fall occurred. During review of hallway camera video footage on 1/11/24 at 11:45 a.m. with DON and administrator identified inconsistencies with the incident report, facility investigation, and staff interviews. The DON indicated the time on the video was within 15 to 30 minutes of the actual time. The video identified the following: -12:37 a.m. LPN-A and LPN-B were in and out of the room 12:42 a.m. LPN-B exited room and 12:45 a.m. LPN-A exited rooms. -12:45 a.m. to 4:40 a.m. staff were noted to be in hallway, however, R1's door remained closed with no visual checks completed. -4:41 a.m. LPN-A noted to be at R1's bedroom door pushing on door and had difficulty opening it. LPN-A was able to gain entrance and had her head through the opening in the door, however, did not enter room. LPN-A walked away from	F 689		

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F 689	Continued From page 51 room with hands down at side in an unrushed manner. -4:42 a.m., NA-A entered room and at 4:45 a.m. A plastic bag was placed outside of the doorway -4:49 a.m., NA-B gowned with personal protective equipment (PPE) and brought a full body mechanical lift to the doorway of the room. Mechanical lift never entered the room. -4:53 a.m., LPN-A entered room with vital signs machine. NA-A exited room with linen in hand and returned to room with pillow and pillowcase. At 4:56 a.m. NA-A exited room and at 5:02 a.m. LPN-A exited room. -5:05 a.m. LPN-B entered the room and exited the room at 5:08 a.m. -5:22 a.m. NA-A returned to the room, exited a couple of seconds later, went back into the room at 5:27 a.m. -5:29 a.m. paramedics arrive, at 5:31 a.m. paramedics entered R1's room, at 5:34 a.m. R1 left with paramedics. During interview on 1/11/24 at 1:16 p.m., following the video review, the DON indicated the camera footage to actual time may vary by 15-30 minutes. Based on the camera footage R1's first and last visual check and last known "well time" before the fall was at 12:45 a.m. when nurse left the room. LPN-A did not immediately enter the room after observing R1 on the floor to complete a physical assessment and left R1 alone. The full body lift was never entered into the room to get R1 off the floor. During interview on 1/10/24 at 4:19 p.m., NP-A indicated she was notified immediately following R1 being found on the floor. She directed facility staff to send R1 to the hospital due to being on anticoagulation medication and reported bleeding	F 689		

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F 689	Continued From page 52 from the head. NP-A indicated a fall with a head strike for a resident who was on blood thinners was a huge risk and would require immediate medical attention, especially an unwitnessed fall. NP-A would expect nursing staff to complete physical assessments right away and would not expect facility staff to attempt to transfer or walk a resident after a fall with a head strike without instruction and was under the impression R1 remained on the floor. During interview on 1/11/24 at 2:05 p.m., hospital medical doctor (MD)-B indicated R1 was pronounced dead at 1:30 p.m. on 1/11/24. The diagnosis of R1's demise was subdural hematoma and hemorrhage. The impact of the fall to R1's head was the cause of death. MD-B indicated there was no reason to believe R1 would have not died if a fall did not occur causing R1 to hit his head. R2's face sheet, undated identified R2 had diagnoses that included cerebral infarction, hemiplegia affecting left nondominant side and neurological neglect syndrome. R2's mobility care plan dated 11/21/23, identified R2 had self-care deficits and required the assist of one to two staff to transfer with the use of a stand pivot with initiated date of 12/18/23. R2 required minimum assist with bed mobility and heel boots on when in bed with an initiation date of 12/5/23. R2's fall care plan dated 12/11/23, identified R2 was high to moderate risk for falls due to right side CVA (Stroke) and staff are to anticipate and meet the residents needs. Place call light within reach and encourage the resident to use it for assistance as needed. The resident	F 689		

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F 689	Continued From page 53 uses "call don't fall sign" to remind R2 to call for assistance. R2's fall risk assessment dated 11/22/23, 12/29/23 and 1/10/24, identified R2 had a history of falls of one to two falls in the past three months. Chair bound and requires assist for elimination and the gait evaluation was not completed. R2 takes one to two medication that may cause lethargy or confusion and had one to two predisposing diseases that could impact fall risk. R2's admission MDS dated 11/27/23, identified R2 did not have cognitive impairment and required substantial to maximal assistance to sit to laying on the edge of the bed, sit to stand and char to bed transfers. Dependent assist for toileting transfers. Substantial maximal assistance to put on take off footwear. MDS identified R1 had a fall in the last month prior to admission, unable to determine if the resident had a fall any time in the last two to six months, and no fracture related to a fall in six months prior to admission. R1 had one fall since admission or prior assessment. R2's incident report dated 1/2/24 identified R2 called for help and was found on the floor facing door. Resident description: She was trying to reach wheelchair from the beside and the wheelchair rolled and she fell. Immediate action taken: vitals done, head to toe assessment done, R2 transferred back to bed via full mechanical lift and three staff and provider updated. Injury type left shoulder (front). Level of pain 5. No injuries observed post incident. Predisposing environmental factors: other, physiological factors were confusion, gait imbalance, and other,	F 689		

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SOUTHVIEW ACRES HEALTHCARE CENTER	2000 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 54 predisposing situational factors included call light within reach. R2 tries to be independent. Notes dated 1/3/24, IDT review of fall: R2 interviewed post fall. Stated she was sitting on beside. Decided she needed to reach for something on the wheelchair or was reaching for the wheelchair. Wheelchair rolled on her and tray table skidded across the floor and she fell. Landing strip placed at bedside. Wheelchair moved away from bedside. Grabber made sure was within reach and call don't fall sign to be placed on wall under the TV. Patient denied injury, only concerned about when she can leave room to smoke. R2's care plan was not revised with the aforementioned interventions other than placing the sign. R2's progress noted dated 1/2/24, titled post incident note indicates R1 had a unwitnessed fall from previous shift and fell around 14:30 p.m. and writer got report from outgoing nurse that patient verbalized trying to reach wheelchair and fell. R2 was found on the floor on the left side body facing door. Had no injuries but notified nurse of pain on the shoulder. Skin intact, alert and oriented to situation. Encouraged R2 to always call for help and a call and do not fall sign were to be added to the door. R2's progress note dated 1/3/24, indicated R2 was sleeping most of the night. Woke up complaining pain 10/10 in left shoulder from yesterdays fall. Offered ice pack, requested Tylenol and gave 650 milligrams (mg). Additional note dated 1/3/24, identified current intervention in place appear effective for patient safety, however R2 complaining of pain in left arm with	F 689		

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F 689	Continued From page 55	F 689		

swelling. On-call provider agreed with concern and approved X-rays.

R2's final report from dispatch health imaging dated 01/04/24 identified the reason for exam was due to pain and swelling due to a fall. Study completed 73060 (LT) Xray, humerus, minimum of 2 views. Findings included a fracture of the humeral head and neck. There was no displacement or dislocation or subluxation. Impression identified an acute fracture of the humeral head and neck. A subsequent X-ray was taken on 1/8/24, identified there was no evidence to suggest acute fracture or dislocation, but if there were persistent symptoms, follow-up X-ray or CT (type of imaging) may be obtained if clinically warranted.

During an observation and interview on 1/12/24 at 8:41 a.m., R2's call light noted to be tangled on the lowest part of the bed rail near the floor intertwined with the cord of the bed controls and a heating pad. The button of the call light was sitting on the ground and the clip of the call light was clipped to bed linen. There were no "call don't fall" signs in the room. R2 recalled fall from 1/2/23. R2 indicated she was getting dressed while sitting at the edge of the bed with a nursing assistant (NA). R2 reported the NA informed her she would be right back because she had someone on the toilet. The NA was not coming back, R2 started looking for the call light, however it was tangled up at the bottom of the side rail. When attempting to reach for the call light her feet slid forward as she was wearing socks without shoes and fell to the floor. R2 recalled hitting the floor hard bruising her hip, breaking her arm, and ongoing pain from the event. When asking R2 where call light was R2 reported

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F 689	Continued From page 56 "probably where I can't reach it", which is an ongoing issue. R2 stated she needed the call light for help because she could not move very well following her stroke. R2 reported recalling a call don't fall sign in her "old room", however did not have one in her current room. During interview on 1/12/24 at 11:20 a.m., nursing assistant (NA)-C indicated she was familiar with R2 and was unaware if R2 had any falls. Any resident that were high risk of falls, their bed should always be lowered, a bed matt should be put in place, never leave residents on the edge of the bed, and always provide the call light by clipping it to resident's shirts and not to bedding as the bedding can fall to the floor. NA-C was unaware of any signs in R2's room for falling. During interview on 1/12/24 at 11:49 a.m., LPN-C stated she was in the hallway on 1/2/23, heard knocking and R2 yelling "help me, help me" coming from R2's closed door. She found R2 laying next to the door and no call light was activated. During interview on 1/12/23 at 11:39 a.m. RN-C indicated R2 fell at the change of shift was found by LPN-C on the floor. RN-C reported R2 was attempting to grab something while sitting at the edge of the bed, and slid off the bed. RN-C indicated R2 crawled to the door of the main entrance to the room the door was closed and the call light was on. RN-C reported doing range of motion as R2 reported pain in the shoulder. RN-C declined doing neurological checks due to R2 declined hitting head. RN-C reported RN-B took over for her following the remaining shift. The following day RN-C cared for R2 and ongoing reports of pain in the shoulder and R2 was unable	F 689		

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F 689	Continued From page 57 to move arm or complete range of motion. RN-C indicated calling provider and received an order to complete an Xray. During interview on 1/12/24 at 1: 44 p.m., RN-B described R2 as impulsive, a high risk for falls, unaware of her own abilities and tried to do tasks in which she can't do on her own, such as reaching for things. RN-B indicated to be involved in two falls for R2 and the first unwitnessed fall on 11/22/23, was due to R2 trying to reach her call button and get something. The second fall on 1/2/24, RN-B was notified by RN-C at the start of RN-B's shift. Upon arrival into R2's room RN-B recalled R2 to be right next to the entrance door. The door was open as staff had been in the room, RN-B was unsure if the call light was on. RN-B completed risk management, notified clinical team and tried to contact family. The interventions in place included keeping R2's bedroom light on, bed in lowest position, and provide education to use call light. During interview with clinical manager (CM)-B on 1/12/24 at 11:55 a.m., CM-B reported his role was to review care plans, root cause analysis of falls and complete the facilities risk management. CM-B reported R2 had two unwitnessed falls in the facility 11/22/23 and 1/2/24. R2 fell on 11/22/23, the day after admission and the root cause of fall was R2 attempting to reposition self in bed and didn't ask for help. CM-B reported R2 had her call light at the time of the fall reporting "everyone always has their call light in reach". The intervention put in place was updating the care plan to R2 required minimum assist with bed mobility. Prior to the update there was no assist level identified. CM-B did not reassess the fall risk as there was no initial fall risk completed.	F 689		

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F 689	Continued From page 58 CM-B indicated R2 was a high fall risk at the time of admission due to physical limitations. CM-B reported the fall on 1/2/24, was due to R2 reaching for the wheelchair from sitting on the bed, the wheelchair rolled away, and she fell in an attempt to self transfer. The call light was on, the door was closed, and it was RN-B that located R2. R2 had no injuries, education provided to call for help and a "call don't fall sign was put on the door". CM-B reported causal analysis of the fall included interviews with R2 and RN-B. R2 was complaining of pain and the determination for further assessment of injury was required . CM-B indicated R2 was not found by the bedroom door, R2 did not crawl anywhere following the fall. CM-B was unaware of what was on R2's feet at the time of the fall. Interventions in place included "fall don't call sign" and interventions in place appear affective for patient safety. A functional mobility assessment was completed following the fall, however the post fall risk assessment was not completed until 1/10/24. During interview on 1/12/24 at 12:41 p.m., DON indicated the intervention put in place for R2 following 11/22/23 fall was to continue with therapy to improve independence. The immediate intervention was notification to the on-call provider and for R2 to be monitored for pain. Following R2's second fall on 1/2/24, a fall don't call sign was placed on the door and patient education provided to use call light. DON was unsure if door was open or closed, unsure what was on R2's feet at the time of the fall, and if the call light was in reach. DON would expect the sign to still be in R2's room, but due to COVID and room changes it may not. DON reported that a repeat Xray of R2's shoulder revealed that R2 did not have a fracture, however that	F 689		

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F 689	Continued From page 59 documentation was not scanned into R2's medical record. During interview with DON and Administrator on 1/12/24 at 5:07 p.m., indicated all residents who have high fall risk factors should have appropriate interventions to mitigate the risk of falling. The purpose of care planning was to direct the care of the patient and care plans need to be accurate and updated to ensure the appropriate interventions are provided to residents. Policy dated 10/4/21 titled Falls-Clinical protocol identified for facility staff to: Assessment and Recognition The physician will help identify individuals with a history of falls and risk factors for falling, Staff will ask the resident and the caregiver or family about a history of falling; The staff and physician will document in the medical record a history of one or more recent falls (for example, within 90 days). While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause include: Precipitating factors, details on how fall occurred, current medications especially those associated with dizziness or lethargy; and all active diagnoses. Cause Identification: For an individual who has fallen staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. After a fall, the physician should review the	F 689		

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F 689	Continued From page 60 resident's gait, balance, and current medications that may be associated with dizziness or falling. A new fall, pain assessment and care plan updated as needed. Review medications, and combinations of medications increase the risk of falling. Staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/10/24 through 1/12/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed. H51898785C (MN000999812) with licensing orders issued at 830, 900, 565 and 1800. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop comprehensive care plans including a toileting plan of care, a pressure sore plan of care, and a skin integrity plan of care for 3 of 3 residents (R1, R4, R5) reviewed for comprehensive care planning. Findings include R1's face sheet identified R1 had diagnoses that included Anoxic brain damage, nuclear cataract, unspecified hearing loss in the left ear, repeated falls, and syncope and collapse. R1's minimum data set (MDS) dated 12/25/23, identified R1 as preferred language of Chinese, R1 wanted or needed an interpreter to communicate with a doctor or health care staff.	2 565	Corrected	2/9/24

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2 565	Continued From page 3 Brief interview for mental status (BIMS) was not completed. R1 required substantial to maximum assist for toileting. R1 had not had a trial of a toileting program and R1 was frequently incontinent of bladder and always incontinent of bowel. A toileting program was not being used to manage the residents continence R1's bowel and bladder program screener dated 12/19/23, R1 never voided appropriately without incontinence, incontinent of stool daily, required assist of one person to get to the bathroom, was alert and oriented, and sometimes mentally aware of the need to toilet. The screener identified R1 was a candidate for a bowel and bladder training program. R1's care plan dated 12/19/23 identified R1 required max assist with toilet use. The care plan did not address a R1's goals for incontinence, toileting program/schedule or other associated individualized interventions. R1's bowel and bladder program screener dated 1/5/24 identified R1 was a candidate for schedule toileting with a score of 13. R1 voided appropriately without incontinence, but less then daily. Was incontinent of stool one to three times a week. Required assist of one person to get to the bathroom, was forgetful but followed commands, and sometimes mentally aware of the need to toilet, and was a candidate for a bowel and bladder training program. In review of R1's record, although the bowel and bladder assessments identified R1 was a candidate for a bowel and bladder training program to improve or maintain function, the care plan did not identify R1's continence goals and individualized toileting needs based on the	2 565		

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2 565	Continued From page 4 assessment. During interview on 1/12/24 at 8:32 a.m., nursing assistant (NA)-A indicated her shift typically started at 11:00 p.m. and R1 would typically be sleeping by the start of NA-A's shift. NA-A would know if R1 needed to go to the bathroom by checking R1's depend. NA-A rarely had to check R1's depend due to R1 not typically being incontinent. NA-A thought R1 used the toilet prior to the start of her shift. NA-A stated she did not recall seeing a urinal in R1's room. During interview on 1/11/24 at 3:38 p.m., director of nursing (DON) explained she expected for staff to anticipate R1's needs for toileting, repositioning, comfort and activities of daily living. DON would expect staff to learn R1's preferences and schedules and anticipate based off what they have learned. If a resident was up in the middle of the night toileting should be offered. DON would expect visual checks on rounds at night and the rounding schedule is every two hours. DON was unaware if R1 could use the call light. Don was unaware of R1's toileting care plan. R4's face sheet noted R4 was admitted to the facility on 12/31/23 with medical diagnoses that included severe protein-calorie malnutrition, adult failure to thrive, hypotension (low blood pressure), anemia (low amount of healthy red blood cells), and Wernicke's encephalopathy (a degenerative brain disorder related to lack of vitamin B). The admission Minimum Data Set (MDS) was not completed as R4 was still in the initial assessment period. R4's Braden Scale for Predicting Pressure Sore Risk dated 12/31/23, was a score of 12 indicating R4 was at high risk for developing pressure	2 565		

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2 565	Continued From page 5 sores. R4's Functional Abilities and Goals Assessment dated 1/2/24, identified that R4 used a manual wheelchair and walker for mobility, needed moderate assist moving from lying to sitting to standing and transferring to/from chair or bed. R4's New Patient Progress Note by nurse practitioner-A (NP-A) dated 1/2/24, noted that R4 was admitted with a developing sacral pressure ulcer. R4's care plan included focuses on pressure ulcers and skin integrity initiated on 1/2/24 that were not completed. The pressure ulcer focus included "The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for ulcer development r/t [related to]." No goal or interventions were identified for R4's pressure ulcer. The focus on skin integrity indicated "The resident has potential/actual impairment to skin integrity" with goal identified to maintain or develop clean and intact skin by review date. Interventions included application of barrier cream after incontinent episodes, keep skin clean and dry, use lotion on dry skin. Incomplete interventions included use of unspecified medical equipment for protecting skin while in wheelchair and bed. The care plan did not address R4's known pressure ulcer on admission and did not address individualized interventions needed to maintain R4's skin integrity. R4's Integrated Wound Care initial consultation note by NP-B dated 1/2/24, identified a stage 1 pressure ulcer on R4's coccyx and further identified that R4 was incontinent of bowel and relied on staff for bed mobility and transfers. Treatments included offload reposition and turn	2 565		

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2 565	Continued From page 6 R4 every 2 hours and as needed. It further specified that the plan of care was discussed with facility staff. R4's care plan did not contain revisions to include the direction to offload R4 every two hours and as needed. R4's Integrated Wound Care follow-up progress note by NP-B dated 1/9/24, identified the coccyx pressure ulcer as stage 2. Treatment instructions continued to include offload, reposition, and turn R4 every 2 hours and as needed. The care plan did not include revisions to include the off-loading schedule direction from NP-B. During interview on 1/11/24 at 5:18 p.m., director of nursing (DON) stated treatment instructions from R4's Integrated Wound Care note from 1/2/24 included turning and repositioning. DON would expect the recommendation from the wound consult to be on the care plan, R4's care plan for skin does not recommend turning and repositioning, and turning and repositioning are standards of practice with pressure ulcers. DON stated the facility's responsibility with the treatment and prevention of pressure ulcers included ensuring interventions were in place, including care planning. R5's quarterly Minimum Data Set (MDS) assessment dated 12/12/23, indicates R5 was admitted to the facility on 8/4/23 with medical diagnoses including articular cartilage disorder of right hip (damage to the cartilage cushioning the hip joint), tendency to fall, weakness, intellectual disabilities, atherosclerosis (buildup of fatty plaques in arteries) polyosteoarthritis, anemia, heart failure, type 2 diabetes with hyperglycemia (elevated blood sugar levels), chronic obstructive pulmonary disease, and malnutrition. R5's Brief Interview for Mental Status (BIMS) score was 8,	2 565		

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2 565	Continued From page 7 indicating moderate cognitive impairment. R5 utilized a walker and ambulated independently, was independent with mobility in bed and transfers from bed to chair, required moderate assistance with toileting, and required maximal assistance with bathing. R5 had a suprapubic (indwelling) catheter and was occasionally incontinent of bowel. The care area assessment (CAA) for pressure ulcer/injury for R5, signed on 8/17/23, notes risk factors included pressure, incontinence, cognitive loss limiting mobility, use of opioid medications, diagnoses of diabetes and severe pulmonary disease, and other complicating factors included R5 being newly admitted. The CAA indicated identification of potential casual factors for impaired skin integrity, but the record did not include documentation of the implementation of corresponding interventions. R5's care plan focus for skin dated initiated on 8/4/23, and resolved on 9/7/23 noted resident has actual impairment to skin integrity. Interventions included apply barrier cream after each incontinent episode, keep skin clean and dry, use lotion on dry skin, resident needs pressure relieving cushion to protect skin while in wheelchair, and resident needs pressure relieving mattress and pillow to protect skin while in bed, all marked as resolved between 9/1/23 and 9/7/23. After 9/7/23, a focus on skin was no longer active/included on R5's care plan. An initial incident progress note by nursing dated 12/26/23, indicated R5 was assessed and found to have skin alteration on left foot between 3rd and 4th toes, area dark purple/black, reddened periwound area (skin surrounding a wound) extending to top of foot. An unidentified wound	2 565		

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2 565	Continued From page 8 nurse practitioner (NP) assessed wound as an unstageable pressure ulcer (full severity of pressure wound cannot be determined because it is obscured by slough (wet light-colored dead tissue) and/or eschar (dry hard dark colored dead tissue)) and recommended an antibiotic. Writer noted they will try to obtain less constricting shoes for R5. R5's Wound Evaluation report dated 12/26/23 by clinical manager-C (CM-C), notes wound #1 was an unstageable pressure wound located on left dorsum 3rd interdigital space (space between the 3rd and 4th toes on the top side of the left foot), wound was acquired in the facility 2 days prior. Treatment included wound care orders for cleanings and dressing and additional care included customized footwear. The care plan was not revised to address wound #1 which was identified as a pressure ulcer, on R5's left foot. Interventions to improve or stabilize R5's impaired skin integrity were not care planned. This precluded monitoring of effectiveness and subsequent updating of the care plan and interventions as appropriate. R5's Wound Evaluation report of wound #2 by unknown author dated 1/7/24, notes an undiagnosed type of wound that measured 0.56 cm^2 in area. The photo attached to the evaluation showed an open area on the bottom of the tip of the third toe on the left foot that extended through the outer layer of skin and was bright red without visible drainage surrounded by pale wet-appearing skin peeling off along the right edge of the wound. R5's care plan was not revised to identify the 2nd toe wound. This precluded monitoring of effectiveness and subsequent updating of the care plan and	2 565		

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2 565	Continued From page 9 interventions as appropriate. At 11:33 a.m. on 1/10/24, a nursing progress note indicted on assessment R5's toe was 100% necrotic and stiff with discoloration of foot in general, identified as a major change since last assessed and photographed on 1/7/24. Unidentified NP was updated on wound deterioration and orders given to send R5 to emergency department. R5 was transported to the hospital by emergency medical services. During an interview on 1/12/24 at 5:18 p.m., director of nursing (DON) stated R5 went to the hospital this week because he had a toe that started changing and he was sent out for evaluation. DON stated the Skin and Wound Evaluation of wound #1 dated 1/10/24 does not have all information completed but does identify an in-house acquired pressure ulcer on R5's left dorsum 3rd interdigital space. The wound wasn't present upon admission. DON stated R5's care plan for skin directs to keep skin clean and dry, use lotion on dry skin, and barrier cream after incontinence, but interventions for the toe are not on R5's care plan and care planning was not done for the wounds. If there is a new skin issue that is a pressure ulcer, the nurse would need to do a report, notify family and providers, request orders for treatment, and ensure interventions are in place such as medical equipment and supplies, care planning, and nutrition. Policy and procedure titled Care Plans, comprehensive person-centered dated 11/30/21, identified the purpose is to have measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.	2 565		

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2 565	Continued From page 10 incorporate identified problem areas; h. incorporate risk factors associated with identified problems; i. build on the resident's strengths; k. reflect treatment goals, timetables and objectives in measurable outcomes; l. identify the professional services that are responsible for each element of care; m. aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. reflect currently recognized standards of practice for problem areas and conditions. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 14. The interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on comprehensive care plans. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could	2 565		

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2 565	Continued From page 11 audit to ensure all staff members are aware of care plan process, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess fall risk and implement appropriate fall interventions to decrease the risk for 2 of 3 residents (R1, R2) with falls. This resulted in harm for R1 who sustained two serious head injuries, was transferred to the hospital, and later died as a result of his injuries. Findings include: Vulnerable adult maltreatment report submitted to	2 830	Corrected	2/9/24

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2 830	Continued From page 12 the State Agency dated 1/8/24, identified R1 was discharged from hospital on 12/19/23 and admitted to transitional care unit (TCU). R1 was readmitted to hospital on 1/6/24 . R1 was diagnosed with subdural hematoma, subarachnoid hemorrhage, parietal skull fracture, deep tissue injury to left heel, pressure injury to the coccyx. None of these conditions were present at the time of discharge from the hospital on 12/19/23. R1's Face Sheet undated, identified R1 had diagnoses that included anoxic brain damage (lack of oxygen to the brain), nuclear cataract (excessive yellowing center of eye), unspecified hearing loss in the left ear, repeated falls, syncope (dizziness) and collapse (fall or give away). R1's fall risk assessment dated 12/19/23 identified R1 was a high fall risk with a score of 11, and had one to two falls in the last three months. R1 was chair bound and required assistance with elimination. Evaluation of R1's gait was not performed, and R1 was on medications that caused lethargy or confusion. R1 had predisposing diseases that impacted his fall risk. R1's admission assessment 12/19/23, identified R1 had a fall in the last month prior to admission to the facility. R1 was transferred from home to the hospital on 12/12/23 for an evaluation following a fall with syncope. Further identified, R1 was a Cantonese speaker and required the use of an interpreter. R1 had moderate difficulty with ability to hear, and no hearing aids or appliances were normally used. R1's family member (FM)-A was available and helped with admission assessment and anytime they needed	2 830		

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2 830	Continued From page 13 to interpret tasks for R1. FM-A informed facility staff resident was hard of hearing and an IPad interpretation may not help. R1's bowel and bladder program screener dated 12/19/23, indicated R1 required assistance of one person to get to the bathroom, was alert and oriented, and sometimes mentally aware of the need to toilet. The screener identified R1 was a candidate for a bowel and bladder training program. There was no indication a bowel and bladder program had been initiated. R1's care plan dated 12/21/23 identified R1 was at a high risk for falls due to a history of recent falls. The care plan directed staff to anticipate and meet needs, ensure the call light was in reach, and encourage resident to use call light as needed. R1 required prompt response to all requests for assistance. Physical therapy was to evaluate and treat as ordered or as needed, and R1 required assist of one with a front wheeled walker for transfers. The care plan did not identify a toileting schedule and/or a positioning schedule. R1's initial Minimum Data Set (MDS) dated 12/25/23, identified R1's preferred language of Chinese, and R1 needed or wanted an interpreter to communicate with a doctor or health care staff. Brief interview for mental status (BIMS, to assess cognition) was not completed. R1's assessment for lying to sitting on the side of the bed and ability to sit to stand were not applicable and not attempted. R1's chair to bed transfer required dependent assist and toilet transfer required substantial to maximum assist. R1 required substantial to maximum assist for toileting. R1 had not had a trial of a toileting program and R1 was frequently incontinent of bladder and always incontinent of bowel. A toileting program was not	2 830		

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2 830	Continued From page 14 being implemented to manage continence. R1's fall Care Area Assessment (CAA) with an assessment reference date of 12/25/23, indicated R1 had an actual fall in the last month prior to admission. However, R1's history of falling and physical performance limitations were not complete. Medications included diuretics and internal risk factors of circulatory/heart (cardiac dysrhythmias) neuromuscular/functional (incontinence and traumatic brain injury) perceptual (hearing impairment) orthopedic (arthritis) psychiatric (cognitive impairment). The care plan was not completed or identified any goals or overall objectives as a result of the CAA. R1's fall risk dated 1/5/24 identified R1 was a high fall risk with a score of 13. R1 had no falls in the past three months, was ambulatory and incontinent. R1 had balance problems with standing and walking, decreased muscular coordination, and required use of an assistive device. R1's incident report dated 1/6/24, indicated R1 had an unwitnessed fall and was found lying on the floor at 5:30 a.m. He was on his right side at the back of his room door. R1 hit the back of his head and had a laceration approximately size of a dime. R1 was shivering with a blanket partially covering his body and was unable to explain what occurred due to not speaking English. Nursing assistant reported the last time she checked on resident, he was sleeping soundly in bed. Immediate action taken was physical assessment, and vitals signs (blood pressure 115/45, pulse 88, tempature 97.3 and respirations 18).Was unable to complete pain assessment and R1 was assisted back to bed with the use of a Hoyer lift (full body mechanical lift) by two	2 830		

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2 830	Continued From page 15 nursing staff. Level of pain rated at a score of three with facial expressions being sad, frightened, frowned body language tensed, distressed pacing, conceivability distracted or reassured by voice or touch. There were no predisposing environmental factors, physiological factors. Predisposing situation factors included using walker, call light within reach, ambulating without assist. Corresponding note dated 1/8/24, indicated interdisciplinary team (IDT) review of fall; patient last observed less then 60 minutes prior to fall or roll out of bed. Care plan followed. Patient did have a history of laying very close to the side of bed. Will look at and change care plan when R1 returns from emergency room and can get input from FM-A. R1's medical record from 1/5/24 to 1/6/24 between 11:00 p.m. and 5:30 a.m., had no documentation R1 was provided with any cares and/or was toileted. During interview on 1/10/24 at 10:55 a.m., (FM)-A indicated R1 resided with him prior to being admitted to the TCU. R1 had three falls while at home and the first fall happened due to R1 trying to get out of bed on his own and reported needing to go to the bathroom. The second fall happened while going down stairs, and the third fall happened attempting to get to the bathroom on his own. FM-A indicated R1 had the desire to go to the bathroom frequently and would attempt to go on his own. FM-A was notified of the fall on 1/6/24 and asked why R1 was on the floor. When FM-A arrived at the hospital R1 informed him he was trying to go to the bathroom. During interview on 1/10/24 at 1:33 p.m., licensed practical nurse (LPN)-A identified she was R1's nurse the night of the fall. The last time she was	2 830		

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2 830	Continued From page 16 in R1's room was to give intravenous therapy (IV) medications (fluids) at around 12:30 a.m. LPN-A reported R1 was COVID positive and R1's bedroom door had been closed. Around 5:30 a.m. LPN-A went to check on R1 and attempted to open the door a few times but noted resistance. LPN-A was able to gain visual entrance to the room and saw R1's head against the backside of the door causing the resistance. R1 was laying on the floor and had a blood smear and a laceration (cut) on the back of his head. R1 was breathing fast and shaking. LPN-A noted blood smears and drops of blood around the bathroom and entrance to the room. LPN-A indicated it was as if R1 was coming out of the bathroom had fallen. He was positioned between the room entrance and bathroom entrance. LPN-A left R1 unattended to go get assistance from nursing assistant (NA)-A and asked when NA-A last provided cares and timing however, timing reports were inconsistent. LPN-A explained NA-A reported to her she did not toilet R1 on the last check because he was sleeping and R1 was supposed to use his call light. Then NA-A went back to assist R1 and LPN-A called nurse practitioner (NP), 911, and the nurse manager. LPN-A reported it was an unwitnessed fall with a head strike and R1 was on anticoagulation. LPN-A went back into the room to complete vitals and assessment. During interview on 1/11/24 at 2:30 p.m., LPN-B indicated she helped LPN-A with R1 the night of the fall with the IV around 12:30 a.m. R1 was awake at 12:30 p.m. and was in bed the whole time during the interaction. The second time LPN-B was in the room was after R1 had fallen and was already transferred back into bed. LPN-B indicated LPN-A had not called 9-1-1 at that time so instructed for LPN-A to call 9-1-1, NP	2 830		

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2 830	Continued From page 17 and family. During interview on 1/10/24 at 3:52 p.m., nursing assistant (NA)-A indicated LPN-A had left R1 to find her to notify her of the fall. NA-A entered the room alone and visualized R1's head against the door to enter R1's room. R1 had dried blood matted in his hair, dried blood on both hands, dried blood spots of blood on the floor, and dried blood on the door of the bathroom. NA-A indicated it looked as though R1 was coming out of the bathroom himself and fell hitting his head on the bathroom door. R1 had gotten a blanket somehow because it was over him. R1 was only in a hospital gown and shivering, he said he was cold. NA-A transferred R1 from the floor to a standing position with the use of a transfer belt and walked him with a walker from the entrance of the room to his bed. R1 was sitting on the edge of the bed while NA-A cleaned all the blood off of him and changed his gown to get him ready to go to the hospital. NA-A was unaware of the last time R1 was toileted but thought R1 had gotten up to go use the bathroom alone and fell. NA-A stated the director of nursing,clinical manager or administrator had not asked any questions about the event since the date of the fall. NA-A indicated even though the blood that was in R1's hair, on the floor, and on the bathroom door was dried, she did not think R1 was not on the floor too long because she had just been in the room between 4:00 a.m. to 4:30 a.m. During an interview on 1/11/24 at 3:59 p.m., clinical manager (CM)-A indicated R1 was expected to use his call light, but only used it very very few times because R1 did not really understand. CM-A could not confidently say if R1 knew how to use the call light. Staff were suppose to check on R1 frequently and anticipate	2 830		

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	00102	A. BUILDING: _____ B. WING _____	C 01/12/2024

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2 830	Continued From page 18 basic needs such as food and toileting due to communication barriers. It was expected staff are anticipating needs visually and should be checking during rounds no longer than an hour to confirm resident safety and avoid accidents such as falls . If residents are up in the middle of the night it was the expectation staff would offer toileting. Staff were to be visually checking residents on walking rounds if the door was closed. R1's door was kept open until testing positive for COVID on 1/4/24, then R1 was on isolation and his door was kept closed. During interview on 1/10/24 at 3:29 p.m., the director of nursing (DON) indicated the expectation with falls with head strikes include a head to toe physical assessment, neurological examination, and pain assessment to be completed. Moving a resident following a fall with a head strike would depend on the findings of the assessment. DON indicated it would be good nursing practice for the nurse to stay with the resident upon moving a resident following a fall with a head strike. DON was aware of a fall and was notified the next day on 1/7/24 at 11:27 a.m. by the day shift charge nurse. The investigation involved asking if the care plan was followed at the time of the fall, the last known "well time," and if there was anything suspicious regarding the fall. DON indicated R1's last known well time was approximately 4:30 a.m., an hour before the fall and the nursing assistant who was involved was nursing assistant (NA)-B, however did not have time to confirm if that was accurate. DON was unaware of the last time R1 was toileted as it was not documented. DON did not identify anything suspicious regarding the event of the fall. DON indicated the facility handled the fall and everything was completed appropriately with no concerns following proper protocol and the care	2 830		

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2 830	Continued From page 19 plan was followed. DON indicated R1 had a history of falling very close to his bed prior to admission and the causal analysis was R1 rolled out of bed and crawled to the door. DON did not complete any interviews with nurses or nursing assistants that were present at the time of the fall. During a subsequent interview on 1/11/24 at 11:14 a.m., DON and administrator both indicated they had not reviewed the facility's video footage as part of the fall investigation. DON stated she did not report the fall with major injury because the care plan was being followed. DON ascertained that information through the investigation that consisted of interviewing dayshift charge nurse (RN-A) and the incident report. According to her interview and the documentation of the event, the nursing assistant had reported checking on him an hour before the fall occurred. DON stated she checked the NA charting, however the time documented of that check, was completed after R1 left the facility. DON did not interview any other staff members including the staff that had worked when the fall occurred. During review of hallway camera video footage on 1/11/24 at 11:45 a.m. with DON and administrator identified inconsistencies with the incident report, facility investigation, and staff interviews. The DON indicated the time on the video was within 15 to 30 minutes of the actual time. The video identified the following: -12:37 a.m. LPN-A and LPN-B were in and out of the room 12:42 a.m. LPN-B exited room and 12:45 a.m. LPN-A exited rooms. -12:45 a.m. to 4:40 a.m. staff were noted to be in hallway, however, R1's door remained closed with no visual checks completed. -4:41 a.m. LPN-A noted to be at R1's bedroom	2 830		

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2 830	Continued From page 20 door pushing on door and had difficulty opening it. LPN-A was able to gain entrance and had her head through the opening in the door, however, did not enter room. LPN-A walked away from room with hands down at side in an unrushed manner. -4:42 a.m., NA-A entered room and at 4:45 a.m. A plastic bag was placed outside of the doorway -4:49 a.m., NA-B gowned with personal protective equipment (PPE) and brought a full body mechanical lift to the doorway of the room. Mechanical lift never entered the room. -4:53 a.m., LPN-A entered room with vital signs machine. NA-A exited room with linen in hand and returned to room with pillow and pillowcase. At 4:56 a.m. NA-A exited room and at 5:02 a.m. LPN-A exited room. -5:05 a.m. LPN-B entered the room and exited the room at 5:08 a.m. -5:22 a.m. NA-A returned to the room, exited a couple of seconds later, went back into the room at 5:27 a.m. -5:29 a.m. paramedics arrive, at 5:31 a.m. paramedics entered R1's room, at 5:34 a.m. R1 left with paramedics. During interview on 1/11/24 at 1:16 p.m., following the video review, the DON indicated the camera footage to actual time may vary by 15-30 minutes. Based on the camera footage R1's first and last visual check and last known "well time" before the fall was at 12:45 a.m. when nurse left the room. LPN-A did not immediately enter the room after observing R1 on the floor to complete a physical assessment and left R1 alone. The full body lift was never entered into the room to get R1 off the floor. During interview on 1/10/24 at 4:19 p.m., NP-A indicated she was notified immediately following	2 830		

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2 830	Continued From page 21 R1 being found on the floor. She directed facility staff to send R1 to the hospital due to being on anticoagulation medication and reported bleeding from the head. NP-A indicated a fall with a head strike for a resident who was on blood thinners was a huge risk and would require immediate medical attention, especially an unwitnessed fall. NP-A would expect nursing staff to complete physical assessments right away and would not expect facility staff to attempt to transfer or walk a resident after a fall with a head strike without instruction and was under the impression R1 remained on the floor. During interview on 1/11/24 at 2:05 p.m., hospital medical doctor (MD)-B indicated R1 was pronounced dead at 1:30 p.m. on 1/11/24. The diagnosis of R1's demise was subdural hematoma and hemorrhage. The impact of the fall to R1's head was the cause of death. MD-B indicated there was no reason to believe R1 would have not died if a fall did not occur causing R1 to hit his head. R2's face sheet, undated identified R2 had diagnoses that included cerebral infarction, hemiplegia affecting left nondominant side and neurological neglect syndrome. R2's mobility care plan dated 11/21/23, identified R2 had self-care deficits and required the assist of one to two staff to transfer with the use of a stand pivot with initiated date of 12/18/23. R2 required minimum assist with bed mobility and heel boots on when in bed with an initiation date of 12/5/23. R2's fall care plan dated 12/11/23, identified R2 was high to moderate risk for falls due to right side CVA (Stroke) and staff are to anticipate and meet the residents needs. Place	2 830		

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2 830	Continued From page 22 call light within reach and encourage the resident to use it for assistance as needed. The resident uses "call don't fall sign" to remind R2 to call for assistance. R2's fall risk assessment dated 11/22/23, 12/29/23 and 1/10/24, identified R2 had a history of falls of one to two falls in the past three months. Chair bound and requires assist for elimination and the gait evaluation was not completed. R2 takes one to two medication that may cause lethargy or confusion and had one to two predisposing diseases that could impact fall risk. R2's admission MDS dated 11/27/23, identified R2 did not have cognitive impairment and required substantial to maximal assistance to sit to laying on the edge of the bed, sit to stand and char to bed transfers. Dependent assist for toileting transfers. Substantial maximal assistance to put on take off footwear. MDS identified R1 had a fall in the last month prior to admission, unable to determine if the resident had a fall any time in the last two to six months, and no fracture related to a fall in six months prior to admission. R1 had one fall since admission or prior assessment. R2's incident report dated 1/2/24 identified R2 called for help and was found on the floor facing door. Resident description: She was trying to reach wheelchair from the beside and the wheelchair rolled and she fell. Immediate action taken: vitals done, head to toe assessment done, R2 transferred back to bed via full mechanical lift and three staff and provider updated. Injury type left shoulder (front). Level of pain 5. No injuries observed post incident. Predisposing environmental factors: other, physiological factors	2 830		

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2 830	Continued From page 23 were confusion, gait imbalance, and other, predisposing situational factors included call light within reach. R2 tries to be independent. Notes dated 1/3/24, IDT review of fall: R2 interviewed post fall. Stated she was sitting on beside. Decided she needed to reach for something on the wheelchair or was reaching for the wheelchair. Wheelchair rolled on her and tray table skidded across the floor and she fell. Landing strip placed at bedside. Wheelchair moved away from bedside. Grabber made sure was within reach and call don't fall sign to be placed on wall under the TV. Patient denied injury, only concerned about when she can leave room to smoke. R2's care plan was not revised with the aforementioned interventions other than placing the sign. R2's progress noted dated 1/2/24, titled post incident note indicates R1 had a unwitnessed fall from previous shift and fell around 14:30 p.m. and writer got report from outgoing nurse that patient verbalized trying to reach wheelchair and fell. R2 was found on the floor on the left side body facing door. Had no injuries but notified nurse of pain on the shoulder. Skin intact, alert and oriented to situation. Encouraged R2 to always call for help and a call and do not fall sign were to be added to the door. R2's progress note dated 1/3/24, indicated R2 was sleeping most of the night. Woke up complaining pain 10/10 in left shoulder from yesterdays fall. Offered ice pack, requested Tylenol and gave 650 milligrams (mg). Additional note dated 1/3/24, identified current intervention in place appear effective for patient safety, however R2 complaining of pain in left arm with	2 830		

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2 830	Continued From page 24 swelling. On-call provider agreed with concern and approved X-rays. R2's final report from dispatch health imaging dated 01/04/24 identified the reason for exam was due to pain and swelling due to a fall. Study completed 73060 (LT) Xray, humerus, minimum of 2 views. Findings included a fracture of the humeral head and neck. There was no displacement or dislocation or subluxation. Impression identified an acute fracture of the humeral head and neck. A subsequent X-ray was taken on 1/8/24, identified there was no evidence to suggest acute fracture or dislocation, but if there were persistent symptoms, follow-up X-ray or CT (type of imaging) may be obtained if clinically warranted. During an observation and interview on 1/12/24 at 8:41 a.m., R2's call light noted to be tangled on the lowest part of the bed rail near the floor intertwined with the cord of the bed controls and a heating pad. The button of the call light was sitting on the ground and the clip of the call light was clipped to bed linen. There were no "call don't fall" signs in the room. R2 recalled fall from 1/2/23. R2 indicated she was getting dressed while sitting at the edge of the bed with a nursing assistant (NA). R2 reported the NA informed her she would be right back because she had someone on the toilet. The NA was not coming back, R2 started looking for the call light, however it was tangled up at the bottom of the side rail. When attempting to reach for the call light her feet slid forward as she was wearing socks without shoes and fell to the floor. R2 recalled hitting the floor hard bruising her hip, breaking her arm, and ongoing pain from the event. When asking R2 where call light was R2 reported "probably where I can't reach it", which is an	2 830		

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2 830	Continued From page 25 ongoing issue. R2 stated she needed the call light for help because she could not move very well following her stroke. R2 reported recalling a call don't fall sign in her "old room", however did not have one in her current room. During interview on 1/12/24 at 11:20 a.m., nursing assistant (NA)-C indicated she was familiar with R2 and was unaware if R2 had any falls. Any resident that were high risk of falls, their bed should always be lowered, a bed matt should be put in place, never leave residents on the edge of the bed, and always provide the call light by clipping it to resident's shirts and not to bedding as the bedding can fall to the floor. NA-C was unaware of any signs in R2's room for falling. During interview on 1/12/24 at 11:49 a.m., LPN-C stated she was in the hallway on 1/2/23, heard knocking and R2 yelling "help me, help me" coming from R2's closed door. She found R2 laying next to the door and no call light was activated. During interview on 1/12/23 at 11:39 a.m. RN-C indicated R2 fell at the change of shift was found by LPN-C on the floor. RN-C reported R2 was attempting to grab something while sitting at the edge of the bed, and slid off the bed. RN-C indicated R2 crawled to the door of the main entrance to the room the door was closed and the call light was on. RN-C reported doing range of motion as R2 reported pain in the shoulder. RN-C declined doing neurological checks due to R2 declined hitting head. RN-C reported RN-B took over for her following the remaining shift. The following day RN-C cared for R2 and ongoing reports of pain in the shoulder and R2 was unable to move arm or complete range of motion. RN-C indicated calling provider and received an order to	2 830		

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2 830	Continued From page 26 complete an Xray. During interview on 1/12/24 at 1: 44 p.m., RN-B described R2 as impulsive, a high risk for falls, unaware of her own abilities and tried to do tasks in which she can't do on her own, such as reaching for things. RN-B indicated to be involved in two falls for R2 and the first unwitnessed fall on 11/22/23, was due to R2 trying to reach her call button and get something. The second fall on 1/2/24, RN-B was notified by RN-C at the start of RN-B's shift. Upon arrival into R2's room RN-B recalled R2 to be right next to the entrance door. The door was open as staff had been in the room, RN-B was unsure if the call light was on. RN-B completed risk management, notified clinical team and tried to contact family. The interventions in place included keeping R2's bedroom light on, bed in lowest position, and provide education to use call light. During interview with clinical manager (CM)-B on 1/12/24 at 11:55 a.m., CM-B reported his role was to review care plans, root cause analysis of falls and complete the facilities risk management. CM-B reported R2 had two unwitnessed falls in the facility 11/22/23 and 1/2/24. R2 fell on 11/22/23, the day after admission and the root cause of fall was R2 attempting to reposition self in bed and didn't ask for help. CM-B reported R2 had her call light at the time of the fall reporting "everyone always has their call light in reach". The intervention put in place was updating the care plan to R2 required minimum assist with bed mobility. Prior to the update there was no assist level identified. CM-B did not reassess the fall risk as there was no initial fall risk completed. CM-B indicated R2 was a high fall risk at the time of admission due to physical limitations. CM-B reported the fall on 1/2/24, was due to R2	2 830		

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2 830	Continued From page 27 reaching for the wheelchair from sitting on the bed, the wheelchair rolled away, and she fell in an attempt to self transfer. The call light was on, the door was closed, and it was RN-B that located R2. R2 had no injuries, education provided to call for help and a "call don't fall sign was put on the door". CM-B reported causal analysis of the fall included interviews with R2 and RN-B. R2 was complaining of pain and the determination for further assessment of injury was required . CM-B indicated R2 was not found by the bedroom door, R2 did not crawl anywhere following the fall. CM-B was unaware of what was on R2's feet at the time of the fall. Interventions in place included "fall don't call sign" and interventions in place appear affective for patient safety. A functional mobility assessment was completed following the fall, however the post fall risk assessment was not completed until 1/10/24. During interview on 1/12/24 at 12:41 p.m., DON indicated the intervention put in place for R2 following 11/22/23 fall was to continue with therapy to improve independence. The immediate intervention was notification to the on-call provider and for R2 to be monitored for pain. Following R2's second fall on 1/2/24, a fall don't call sign was placed on the door and patient education provided to use call light. DON was unsure if door was open or closed, unsure what was on R2's feet at the time of the fall, and if the call light was in reach. DON would expect the sign to still be in R2's room, but due to COVID and room changes it may not. DON reported that a repeat Xray of R2's shoulder revealed that R2 did not have a fracture, however that documentation was not scanned into R2's medical record. During interview with DON and Administrator on	2 830		

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2 830	Continued From page 28 1/12/24 at 5:07 p.m., indicated all residents who have high fall risk factors should have appropriate interventions to mitigate the risk of falling. The purpose of care planning was to direct the care of the patient and care plans need to be accurate and updated to ensure the appropriate interventions are provided to residents. Policy dated 10/4/21 titled Falls-Clinical protocol identified for facility staff to: Assessment and Recognition The physician will help identify individuals with a history of falls and risk factors for falling, Staff will ask the resident and the caregiver or family about a history of falling; The staff and physician will document in the medical record a history of one or more recent falls (for example, within 90 days). While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause include: Precipitating factors, details on how fall occurred, current medications especially those associated with dizziness or lethargy; and all active diagnoses. Cause Identification: For an individual who has fallen staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. If the cause of a fall is unclear, or if a fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help further identify causes and contributing factors. After a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. A new fall, pain assessment and care plan updated as needed. Review medications, and combinations of medications increase the risk of	2 830		

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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
2 830	Continued From page 29 falling. Staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on resident safety and falls. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents are comprehensively assessed and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		2/9/24

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	00102	A. BUILDING: _____ B. WING _____	C 01/12/2024

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2 900	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to perform comprehensive skin assessments and provide interventions for pressure ulcer prevention and treatment for 2 of 3 residents (R4, R1) reviewed for pressure ulcers. Findings include R4's face sheet noted medical diagnoses that included severe protein-calorie malnutrition, adult failure to thrive, hypotension (low blood pressure), anemia (low amount of healthy red blood cells), and Wernicke's encephalopathy (a degenerative brain disorder related to lack of vitamin B). R4's face sheet identified R4 was admitted to the facility on 12/31/23. The admission Minimum Data Set (MDS) was not completed as R4 was still in the initial assessment period. R4's Braden Scale for Predicting Pressure Sore Risk dated 12/31/23, was a score of 12 indicating R4 was at high risk for developing pressure sores. A provider order placed 12/31/23 indicated staff were to monitor R4's sacral dressing every shift and consult the as needed order to replace the dressing if missing or soiled. R4's Skin Audit progress note upon admission dated 12/31/23, identified redness on R4's tailbone with Mepilex dressing intact upon admission. R4's care plan included focuses on pressure ulcers and skin integrity initiated on 1/2/24 that	2 900	Corrected	

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2 900	Continued From page 31 were not completed. The pressure ulcer focus included "The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for ulcer development r/t [related to]" and the focus on skin integrity indicated "The resident has potential/actual impairment to skin integrity." No goal or interventions were identified for R4's pressure ulcer. The goal identified for R4's skin was to maintain or develop clean and intact skin by the review date. Individualized interventions included may apply barrier cream after each incontinent episode, keep skin clean and dry, use lotion on dry skin. Incomplete interventions included "The resident needs (SPECIFY: pressure relieving/reducing cushion, pillows, sheepskin padding etc.) to protect the skin while in wheelchair" and "The resident needs (SPECIFY: pressure relieving/reducing mattress, pillows, sheepskin padding etc.) to protect the skin while IN BED." R4's Functional Abilities and Goals Assessment dated 1/2/24, identified that R4 used a manual wheelchair and walker for mobility, needed moderate assist moving from lying to sitting to standing and transferring to/from chair or bed. R4's New Patient Progress Note by nurse practitioner-A (NP-A) dated 1/2/24, noted that R4 was admitted with a developing pressure ulcer and included a plan for a wound team consult. The physical examination of R4's skin indicated NP-A had not seen the sacral side of R4 but noted in the chart that R4 had a developing pressure ulcer. R4's Integrated Wound Care initial consultation note by NP-B dated 1/2/24, identified a stage 1 pressure ulcer on R4's coccyx measuring 2.2 centimeters squared (cm^2) in area and further	2 900		

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2 900	Continued From page 32 identified that R4 was incontinent of bowel and relied on staff for bed mobility and transfers. Treatments included offload reposition and turn R4 every 2 hours and as needed. It further specified that the plan of care was discussed with facility staff. It was not evident the care plan was revised to include the direction to offload R4 every two hours and as needed. R4's Wound Evaluation dated 1/2/24 by CM-B noted a stage 2 pressure ulcer (partial-thickness skin loss with exposed dermis) on the coccyx measuring 1.64 cm² in area. In review of R2's record, it did not identify and/or account for the differences between NP-B's determination of stage 1 ulcer measuring 2.2 cm² and CM-B's determination of stage 2 ulcer measuring 1.64 cm² completed on the same day. R4's Integrated Wound Care follow-up progress note by NP-B dated 1/9/24, identified the coccyx pressure ulcer as stage 2 measuring 11.76 cm² in area, 4.9 cm long, and 2.4 cm wide with scant serosanguinous (blood-tinged watery) exudate (drainage), epithelial wound tissue (pink skin with thin layer of new skin), and normal periwound skin (skin surrounding the wound) with stalled healing progress. Treatment instructions included apply Hydrogel and cover the wound with foam (a silicone and foam pad dressing, brand name Mepilex) and change the dressing daily and as needed. Instructions continued to include offload, reposition, and turn R4 every 2 hours and as needed. The plan of care was discussed with facility staff. It was not evident the care plan was revised to include the off-loading schedule. R4's Wound Evaluation dated 1/9/24, by unknown author noted a healable (healing is not slow, stalled, or unachievable) stage 2 pressure ulcer	2 900		

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2 900	Continued From page 33 measuring 8.2 cm² in area, 4.9 cm long, and 2.4 cm wide. Further information including description of the wound bed, signs of infection, exudate, periwound area, wound pain, treatment (cleansing, dressing, and additional cares such as turning and repositioning), and wound progress were not completed. In review of R4's record, it did not identify and/or account for the differences between NP-B's wound measurement of an 11.76 cm² wound with stalled progress and the unknown author's measurement of an 8.2 cm² wound that was healable completed on the same day. During observation on 1/12/2024 at 2:13 p.m., R4 was supine (lying face up) in bed. RN-D assisted R4 with rolling to one side, lowered R4's pants, and observed the coccyx pressure ulcer. The wound was shiny and red with a small approximately 1.3 cm long open slit in the skin to the right of the gluteal cleft with redness extending into R4's perineal area into skin folds at the top of the inner leg and onto genitalia. There was no dressing (Mepilex) present on R4 or visible in R4's clothing or bedding. RN-D stated there was no dressing present. Record review revealed no documentation of a reason for the absence of the dressing, such as the dressing falling off or becoming dirty during cares. R4's treatment administration record for 1/12/24 documented that the dressing had been monitored by the overnight shift and the day shift nursing staff and did not indicate use of the as needed order to replace if missing or soiled. During an interview on 1/12/24 at 2:30 p.m., CM-A stated that there was no dressing present when they entered R4's room during the wound inspection with additional wound care supplies.	2 900		

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2 900	Continued From page 34 Wound care orders were not followed because there was no Mepilex on, the dressing was missing, and the current orders say R4 should have a Mepilex on the pressure ulcer. During interview on 1/11/24 at 5:18 p.m., director of nursing (DON) stated the expectation is nursing staff follow wound care orders, dressings should be in place unless a reason why it was removed has been documented, communicated, and dressing replaced. DON identified treatment instructions from R4's Integrated Wound Care note from 1/2/24 included turning and repositioning. DON would expect the recommendation from the wound consult to be on the care plan, R4's care plan for skin does not recommend turning and repositioning, and turning and repositioning are standards of practice with pressure ulcers. DON stated the facility's responsibility with pressure ulcers is to assess the risk for pressure ulcers, prevent new pressure ulcers, and treat existing pressure ulcers. DON stated that the facility would ensure interventions were in place including care planning and the resident would be referred to the wound team so that the wound certified NP would see and evaluate them on a weekly basis. R1's face sheet identified R1 was admitted to the facility on 12/19/23 and had diagnoses that included anoxic brain damage (a brain injury from lack of oxygen), type 2 diabetes, cataract, heart arrhythmias, gout, dry skin, and repeated falls. R1's admission MDS dated 12/23/23, included a staff assessment for mental status which indicated R1 had memory problems with both short- and long-term memory, was not oriented to current season/location/or staff, and had moderately impaired cognitive skills for daily	2 900		

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2 900	Continued From page 35 decision making. R1 utilized a wheelchair and required moderate assistance with rolling side to side, maximal assistance with toileting hygiene and transfers to/from toilet, and was dependent on staff for transfers between bed and chair. R1's Nurse Admission/Readmission assessment dated 12/19/23, noted a stage 1 (intact skin with non-blanchable redness) right buttock pressure injury and stage 1 left buttock pressure injury with no further description or information. Also identified R1 was incontinent of bowel and bladder. R1's care plan included focuses on pressure ulcers and skin integrity. The pressure ulcer focus initiated on 12/19/23 included the resident is potential [risk, sic] for pressure ulcer development related to fragile thin skin. No goals or interventions related to pressure ulcers were included on the care plan. The skin focus noted the resident has potential/actual impairment to skin integrity, initiated 12/19/23 with goal to maintain or develop clean and intact skin by the review date. Interventions, all initiated on 12/19/23, included application of barrier cream after incontinent episodes, keep skin clean and dry, use lotion on dry skin, the resident needs pressure reducing cushion to protect the skin while in wheelchair, and the resident needs pressure reducing mattress to protect the skin while in bed. R1's Care Area Assessment dated 12/30/23 for pressure ulcer/injury identified R1 had a stage 1 bilateral buttocks pressure ulcer. Analysis of findings section noted to assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin. Corresponding assessment data was not evident	2 900		

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2 900	Continued From page 36 in R1's record. Risk factors identified included pressure, delirium limits mobility, cognitive loss limits mobility, and incontinence. Diagnoses presenting complications or increasing risk for pressure ulcer/injury identified were delirium and malnutrition. Other factors causing complication or increasing risk included devices that can cause pressure. R1's record did not identify the devices that increased the risk. There were no updates to R1's care plan evident after completion of the Care Area Assessment. The care plan did not comprehensively address R1's actual and potential impairment of skin integrity. In review of R1's record it did not have a comprehensive pressure ulcer assessment that identified pressure points for turning and reposition needs, size, depth, wound bed characteristics, drainage and pain. Further not evident the stage 1 ulcers were being treated and continuously monitored for improvement or deterioration after identified upon admission. Vulnerable adult maltreatment report submitted to the State Agency dated 1/8/24, identified R1 was discharged from the hospital on 12/19/23 and admitted to facility's transitional care unit. R1 was readmitted to the hospital on 1/6/24 with a pressure injury to the coccyx. The report did not identify the measurements of the ulcer. The facility's policy titled Care Plans, Comprehensive Person-Centered last reviewed 11/30/21 included: The comprehensive, person-centered care plan will: - incorporate identified problem areas - incorporate risk factors associated with identified problems	2 900		

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2 900	Continued From page 37 - aid in preventing or reducing decline in the resident's functional status and/or functional level - reflect currently recognized standards of practice for problem areas and conditions Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures pressure ulcers and wound management. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents free from the risk of new pressure ulcer development, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written	21800		2/9/24

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21800	Continued From page 38 statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a non-English speaking resident was provided with appropriate interpretive services for 1 of 3 residents (R1). In addition, the facility failed to reevaluate the effectiveness of the services offered, allowing them to be fully informed about their health status in an emergent situation. Findings include: R1's Face Sheet identified R1 had diagnoses that included anoxic brain damage, nuclear cataract, unspecified hearing loss in the left ear, repeated falls, and syncope and collapse.	21800	Corrected	

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21800	Continued From page 39 R1's admission assessment dated 12/19/23, identified R1 was a Cantonese speaker and required the use of an interpreter. R1 had moderate difficulty with ability to hear and no hearing aids or appliances are normally used. Admission summery identifies R1's family member (FM)-A was available and helped with admission assessment and was available anytime to help with interpreting task. FM-A informed facility staff resident was hard of hearing and IPad interpretation might not help much. R1's Minimum Data Set (MDS) dated 12/25/23 identified R1 as preferred language of Chinese and yes was answered if R1 needed or wanted an interpreter to communicate with a doctor or health care staff. R1's care plan dated 12/28/23 identified R1 had impaired cognitive function/dementia or impaired thought process due to impaired decision making. R1 spoke Cantonese and required interpretive services. R1 was unable to use interpreter pad (electronic tablet) due to hearing. FM-A was able to interpret for resident. R1 had a hearing impairment/a potential and intervention included FM-A help with hearing issues. R1's medical record lacked evidence if the facility had obtained other language interpretative services or modalities to assist with R1's communication needs. During interview on 1/12/24 at 9:36 a.m., licensed practical nurse (LPN)-D indicated being part of the admission assessment and R1 required the use of an interpreter. Facility staff were supposed to use the IPad for communication and if not successful to use FM-A to interpret. The assessment was completed with the use of FM-A	21800		

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21800	Continued From page 40 and R1 could usually understand with the use of interpreter. If FM-A was not present. R1 could sometimes follow gestures. During interview on 1/11/24 at 4:25 p.m., director of social services (SW)-A indicated communication with R1 was very difficult. SW-A had only communicated through the use of FM-A interpreting. SW-A provided a Cantonese picture board for communication to R1, however declined attempting to use it or determine if it was successful. Cantonese picture board was not care planned, however staff were to use family and caregivers to be resources for communication. SW-A was unsure of what staff were supposed to do for communication in the middle of the night or if FM-A was unavailable. During interview on 1/10/24 occupational therapist (OT)-A indicated R1 had a language barrier and did not speak English and R1's hearing was not the best. OT-A was unaware who initiated the communication board in R1's room, however typically used FM-A to interpret for therapy sessions. If FM-A was not present OT-A would use basic visual demonstrations for return demonstration in therapy. OT-A stated formal cognitive testing was not completed due to language barriers and R1 being hard of hearing. OT-A was unsure what or how R1 would respond in an emergency situation or in the middle of the night if FM-A was unable to interpret. During interview on 1/10/24 at 3:52 p.m., nursing assistant (NA)-A indicated R1 typically slept throughout the night and communication was not typically needed on the overnight shift. When R1 fell and was found on the floor during the night shift on 1/5 into 1/6/24 R1 did not have interpretive services and communicated by	21800		

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21800	Continued From page 41 gestures indicating he was cold and wanted to lay down. During interview on 1/10/24 at 1:33 p.m., LPN-A indicated upon finding R1 on the ground was initially unsure if R1 was sleeping on the ground and confused or if R1 had fallen. LPN-A indicated that R1 was non-English speaking and was unable to do full assessments following the fall. During interview on 1/12/24 at 5:07 p.m. DON and administrator indicated all residents that have the right for communication services and facility staff should re-evaluate the effectiveness of communication and language barriers. Policy and procedure titled Translation and/or interpretation of facility service dated 12/8/21 identifies facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. 1. When encountering LEP individuals, staff members will conduct the initial language assessment (e.g., "I Speak Cards") and notify the staff person in charge of the language access program. 2. Interpreters and translators must be appropriately trained in medical terminology, confidentiality of protected health information, and ethical issues that may arise in communicating health-related information. a. Family members and friends shall not be relied upon to provide interpretation services for the resident, unless explicitly requested by the resident. If family or friends are used to interpret, the resident must provide written consent for disclosure of protected health information. SUGGESTED METHOD OF CORRECTION:	21800		

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21800	Continued From page 42 The administrator or designee could review/revise policies and procedures on interpreter services. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents and family members are aware of interpreter service resources, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21800		