Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2024

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

RE: CCN: 245205
Cycle Start Date: March 26, 2024

Dear Administrator:

On April 12, 2024, we notified you a remedy was imposed. On May 10, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 2, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 27, 2024 be discontinued as of May 2, 2024. (42 CFR 488.417 (b))

In our letter of April 12, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 27, 2024. 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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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May 15, 2024

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

Re: Reinspection Results
Event ID: U95X12 and KU4P12

Dear Administrator:

On May 9, 2024 and May 10, 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 surveys completed on March 26, 2024 and April 22, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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April 12, 2024

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

RE: CCN: 245205
Cycle Start Date: April 26, 2024

Dear Administrator:

On March 26, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location 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 April 27, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 27, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 27, 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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 April 27, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Anoka Rehabilitation And Living Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 27, 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 26, 2024 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245205	A. BUILDING _____ B. WING _____	C 03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(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 3/21/24, 3/22/24, 3/25/24 and 3/26/24, 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 complaints were reviewed. H52052093C (MN00101744) H52052286C (MN00094480) H52052284C (MN00096246) H52052285C (MN00097170) H52052287C (MN00097294 & MN00098098) H52052329C (MN00094106) H52052333C (MN00098067) H52052331C (MN00098368) H52052332C (MN00101670) with deficiencies issued at (F550, F656, 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F 550		4/25/24

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

Electronically Signed — 04/19/2024

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 550	Continued From page 1	F 550		

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

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F 550	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a dignified living experience was maintained for 2 of 3 residents (R1 and R13) reviewed for dignity. Findings include: R1's face sheet identified R1 had diagnoses including multiple sclerosis (MS), vascular dementia, and hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stoke) affecting right dominate side. R1's quarterly Minimum Data Set (MDS) dated 2/16/24, identified R1 was cognitively intact and required substantial/maximal assist to roll left and right and move from sitting to lying or lying to sitting. R1's care plan dated 9/26/19 identified R1 is at risk for ineffective coping related to diagnosis of MS, depression. R1 has noted behaviors of crying, tearfulness, sadness and is withdrawn at times. Likes to have her routine. She takes an antidepressant. R1 has expressed fear of covid and states she feels content in her room. The goal is for R1 to respond to redirection when tearful. Staff are encouraged and allow her to verbalize her feelings and participate in her cares. Update ND/NP on mood changes. Intervention dated 8/5/11 staff are to listen carefully to R1 and acknowledge feelings and concerns. R1's care sheet for facility staff identifies staff are to approach R1 for toileting by add to toileting routine is a check and change at 10 a.m. daily. Please approach resident and tell her "its time to	F 550	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. DON and Regional Educator had one on one discussion with LPN A and LPN B on resident□s rights to display emotions and should slow down and explain what we are doing with a calm voice. Blinds and doors will be shut/closed during cares . And staff will follow care plans. b. ADON gave verbal education to, and notified staffing agency of, NAR and cold food complaint. Agency reported providing education to NAR 3/25/24 about setting up residents promptly with food . And staff will follow care plans. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. All residents have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. Policies and procedures reviewed and continue to be current b. Education on residents□ rights provided to staff including, dignity, respect, and privacy with blinds, doors being closed during personal cares and as requested, timely serving of food to ensure proper temps, and respect with verbal and non-verbal communication and staff will follow care plans. 4. How the facility will monitor its corrective actions to ensure that the	

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F 550	Continued From page 3 change your brief". Do not ask her "do you want us to change you" or any variation of this. If her pants are wet, tell her " R1- your pants are wet and we need to change them." R1's grievance dated 05/10/23 for R1. Nurse referring to resident as "troublemaker" playfully, but resident does not appreciate it. Resident has been having to wait until 700 to get up, but wants to get back to getting up at 5:00. Nurse re-educated on resident rights. Resident and /or family to notify assistive director of nursing (ADON) or nurse manager of any further issues. ADON is to check in with residents in AM until resolved. During review of the video camera footage recorded on 3/16/24. R1 was crying and had facial grimacing and pointing to her leg. Licensed practical nurse LPN-B was next to the bed while completing cares. R1was grimacing and crying. LPN-A then lifts up R1's right leg and R1 continued to cry harder. LPN-B said " wait wait wait stop crying and when your crying and talking we don't get what you're saying." LPN-B spoke loud and used strong toned body language using his hands for expression. During review of video camera footage recorded on 3/20/2024 R1 leaning over the side of the commode with the window shades open. A nursing assistant entered R1's room and leaves door open. R1's lower body was exposed to the hallway for 23 seconds until another aid came into the room and shut the door. R1's window shade was not closed and viewable to other residents in the courtyard. Staff compelted peri care with the shade opened.	F 550	deficient practice is being corrected and will not recur. a. Using the audit tool, the DON or designee will conduct random audits through staff observations to ensure residents rights are being followed per care plan and x5 per week for x4 weeks with results brought back to the QAPI committee. b. Using the audit tool, the DON or designee will conduct random audits of the temps of resident□s food as it enters the resident□s room to ensure temps are within required range x1 per week for x4 weeks with results brought back to the QAPI committee.	

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F 550	Continued From page 4 During interview on 3/26/2024 at 2:08 a.m., R1 reported its her preference to sit next to the bed and not by the window. R1 prefers to view the T.V. R1 stated she wants to a nice lady to staff so sometimes she will allow nursing staff put it wherever they want before providing care. However, R1 started it was frustrating when staff don't listen to her preferences including the proper positioning to her leg. During interview on 3/21/24 at 5:30 p.m. R1 reported facility staff to not "take her for who she is". R1 indicated needs and preferences are important to her and does not always feel listened to. R1 reported to have a specific way of doing things and sometimes staff will talk over and not listen to her. During interview on 3/21/24 at 8:37 a.m., family member FM-(A) reported to be R1's power of attorney to help advocate for R1. FM-A reported viewing video camera footage which was disturbing to her. The video camera footage included people yelling at R1 and not listening to her needs. FM-A also reported R1 had been being changed in an open environment and the widows were open facing a courtyard and the bedroom door was open viewable to another resident's room while R1 was undressed from the lower half while going to the bathroom and these dignity and respect concerns are going against R1's resident rights. Corrective action dated 10/13/21 identifies the corrective action to be first written warning. Description of violation identified it to be a failure to comply with standards of customer service. Supervisor's comments identify NA-F will take time to listen to residents, Will confirm with	F 550		

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F 550	Continued From page 5 resident that he is moving at a good pace for the resident. Employees comments identify NA-F was shocked by this and feels he had a good interaction with the resident. NA-F understands the importance of good customer service. Coaching provided included reviewing customer service form. Explained all things to patients when turning and repositioning, if something occurs like stepping on a patient's foot, say sorry and tell a nurse so they can assess. Corrective action dated 7/17/22 Incident type includes improper care and failure to follow policy. Documentation of coaching provided included residents need to be moved slowly at their ow pace during cares. Resolution includes any further complaints from residents about rushed care or improperly transferring a resident will result in an immediate corrective action or suspension. Corrective action dated 03/20/2024 identified NA-F received a just in time training and education need: "review education on treating each resident individually with dignity. Prior discussion with employee on this issue identified "No". Retraining summery identified staff reviewed the resident bill of rights and dignity policy (attached) including #14 and #15 and #16 in the policy. Comments: Employee verbalized understanding of the policy and the importance of appropriately verbal communication and treating each resident with respect and dignity. Residents bill of rights and dignity policy dated 10/24/2022 identified the purpose of the policy was to reflect current federal and state standards governing "patients' rights". These rights identify specific prerogatives according to the individual	F 550		

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F 550	Continued From page 6	F 550		

while he/she is a resident at this health care facility. To ensure the proper implementation of the resident's bill of rights, the following procedures are followed.
#14 The facility must enforce and ensure resident rights are enforced, including the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.
#15 the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality.
#16 the facility must promote and protect the rights of the resident.

A returned phone call on 3/27/27 at 10:57 a.m. NA-F recalled having a corrective action regarding the situation. R1 reported to not be aware his voice was that loud and could see why it came across in a different manner. NA-F reported R1 had difficulty with communication and NA-F was trying to understand what she wanted and was unable to understand what she wanted with the pillow positioning due to not knowing R1's needs and preferences.

During interview on 3/22/24 at 11:18 a.m., director of nursing (DON) reported there have been various grievances and care concerns reported by FM-A regarding R1's care. DON had received the email by FM-A and had viewed the one from 3/16/24 and did the training with staff on 3/20/24. DON reported NA-F was suspended. When they interviewed NA-F, he did not know what he did wrong. Typically he is a very soft-spoken person and there could be culture barrier. DON reported the facility did not ensure how R1 felt regarding

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F 550	Continued From page 7 as it could have been traumatic and did not know if it could relate to past trauma. Additionally, the facility had not add added R1's preference to not work with him. DON was unaware what R1's preferences were for the placement and commodes. R13's face sheet identified diagnoses including aphasia following intracranial hemorrhage (difficulty understanding or expressing speech following a brain bleed), morbid (severe) obesity, muscle weakness, and vascular dementia. R13's significant change Minimum Data Set (MDS) dated 1/23/24, R13 required maximal assistance with mobility in bed and was dependent on staff for sitting up, lying down, and transfers. R13 was dependent for toileting hygiene. R13's MDS dated 10/12/23, included the last Brief Interview for Mental Status (BIMS) completed, with a score of 3 indicating severe cognitive impairment. R13 care plan dated 09/26/23 identified R13 triggered in ADL's R13 had preferences and other items of need listed in interventions. R13 required staff to assist with eating. Intervention dated 08/18/21 staff are to assist R13 out of bed for meals. Notify nurse if I refuse. Additionally care plan dated 07/06/2021 identified R13 requires staff to help set up supplies and assist with dressing/grooming/hygiene. Level of assistance and preferences are not identified. R13's care plan dated 01/24/24 for communication identified R13 demonstrated unclear speech slurred or mumbled words,	F 550		

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F 550	Continued From page 8 speaks very little. Resident will have all needs met with anticipation from staff. Staff are to observe facial expressions and body language and attempt to interpret. Email communication on 03/20/2024 at 7:01 from FM-B to administrator, DON, assistant director of nursing (ADON) and NM-A and NM-B included "Same night gown and socks on since Monday [3/18/24] morning. She should be changed daily into clean night gowns and socks." I was told Monday that the care plan was going to be executed which didn't even last one day. We are truly concerned with the level of care being provided in River Bend as a whole with not only mom but other residents as well. We are hoping this sudden change in care for our mom was not reflective of claim filed justifiably with state as we were not the only resident family who filed claims. " During observation of video footage dated 3/20/24, FM-B was in R13's room speaking with the ADON. Video footage shows digital clock time of 11:08 a.m. [due to outside lighting]. During review of video review of conversation with FM-A to ADON. FM-A is expressing the desire for R13 to FM-A expressing R13's preferences related to the care plan being followed. "Consistency, it's all I ask for and for her to get the needs that she needs". FM-A expressed R13's rights and preferences regarding food trays, clothing not being changed and changed back into the same clothing. ADON reported "seems reasonable to me" regarding clothing. ADON reported the plan was to talk with staff. Facility staff failed to address how R13's needs and preferences will be met.	F 550		

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F 550	Continued From page 9 Email communication on 3/25/24 at 11:03 from FM-B to administrator, DON, assistant director of nursing (ADON) and NM-A and NM-B included "This morning the aide brought breakfast to mom at 8:25 am and placed it on tray table lateral to mom unopened. Tray table was never placed over bed nor was my mom lifted up to be able to eat. Food sat on tray table until 9:46 am when mom was taken out of bed and changed. At the time, aide placed tray table to my mom opened cold food which was oatmeal without even heating it up. So food sat almost an hour an a half without her being to get to it and was served very cold. " Email communication had a picture of a staff member walking away towards the direction of the room door while R13 was laying in bed with the tray next to R13's bed. During observation of video camera footage from 3/20/24 at 1:10 p.m., R13 was using a sit to stand EZ-Stand Mechanical lift. Facility staff reported to R13 "don't worry you're not going to fall." When staff asked if R13 was okay she shook her head no, staff did not respond to R13's nonverbal expression. Staff was in viewable position to see R13's nonverbal expressions. During interview on 3/26/24 3:14 with director of nursing (DON), reported that all staff should follow and know how to access up to date care plans. All staff treat residents with dignity and respect in accordance with their residents rights. Facility policy titled resident bill of rights and dignity policy dated 10/24/22 identified the purpose for the resident's bill of rights reflects current federal and state standards governing "patient's rights". These rights identify specific prerogatives according to the individual while he/she is a resident at this health care facility. To	F 550		

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F 550	Continued From page 10 ensure the proper implementation of the resident's bill of rights, the following procedures are followed. 1. If resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate information concerning rights/responsibilities in a language familiar to the resident is used. 2. The facility must enforce and ensure resident rights are enforced, including the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 3. The facility must treat each resident with respect and dignity and care for each resident in a manner and in and environment that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality. 4. The facility must promote and protect the rights of the resident. 5. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all residents regardless of payment source. 6. The facility must ensure that the resident can exercise his/her rights without interference, coercion, discrimination, or reprisal from the facility. 7. The resident has the right to be free of	F 550		

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F 550	Continued From page 11 interference, coercion, discrimination, and reprisal from the facility in exercising his/her rights and to be supported by the facility in the exercise of his/her rights as required.	F 550		
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	F 656		4/25/24

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F 656	Continued From page 12 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 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 observation, interview, and record review the facility failed to develop and implement the toileting care plan for 1 of 2 residents (R13) reviewed for toileting. Findings include: R13's significant change Minimum Data Set (MDS) dated 1/23/24, indicated R13 was admitted to the facility on 9/23/23 with diagnoses including aphasia following intracranial hemorrhage (difficulty understanding or expressing speech following a brain bleed), muscle weakness, non-Alzheimer's dementia, depression, and arthritis. R13 required maximal assistance with mobility in bed and was dependent on staff for sitting up, lying down, transfers, and toileting hygiene. R13 was always incontinent of both bowel and bladder. R13's MDS dated 10/12/23, included the last Brief Interview for Mental Status (BIMS) completed, with a score of 3 indicating severe cognitive impairment.	F 656	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R13 - A comprehensive assessment has been completed regarding bowel and bladder. A toileting care plan was developed based on results of the comprehensive assessment that identifies the individualized toileting plan, residents care plan was updated to reflect appropriate product availability. Immediately looked at the residents brief to ensure it was changed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. 94 out of 117 residents need assistance with toileting have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.	

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F 656	Continued From page 13 R13's Bowel and Bladder Data Collection assessment completed by nurse manager (NM)-B dated 1/20/24, identified R13 was always incontinent of urine, incontinence did not interfere with activities or recreation during the day, R13 slept through the night without interruption and was not being interrupted by a check and change schedule. R13 had no short or long term memory loss, could not identify the need or urge to void/defecate, was sometimes able to use the call light, was not able to ask to use the toilet, did not wake at night to void, did not have incontinent episodes associated with specific actions, and had suspected functional incontinence. The interventions for urinary incontinence were to establish a bladder routine and provide perineal care with pad changes. R13 had not had a trial of a toileting program and was not currently using a toileting program or trial. Diagnoses affecting elimination patterns included obesity, depression, and diabetes. Mobility/environmental limitations which could affect elimination included requiring assistance to transfer and requiring a mechanical lift. R13 was totally dependent for toilet use and required two plus persons for physical assistance. Have new interventions or environmental modifications been added since last review was marked no. The amount of urinary incontinence episodes, number of times the resident wakes at night to void naturally, number of times resident is wakened at night to void by staff, if urinary incontinence is a direct result of a specified illness/injury, when the incontinence started, if resident had problems with leaking urine sections, and if resident showed patterns of urinary incontinence sections of the Bowel and Bladder Data Collection assessment dated 1/20/24 were not completed.	F 656	a. Policies and procedures reviewed and continue to be current. Comprehensive assessments will continue to be completed. Toileting care plans will be developed based on results of the comprehensive bowel and bladder assessment, that identifies the individualized toileting plan. b. Retraining on residents bowel and bladder assessments to incorporate all individual resident toileting care needs, including the care plan / Kardex and nursing assistant tasks 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. Using the audit tool, the DON or designee will conduct random audits of toileting care plans to ensure residents briefs are being changed within the care plan specifications x5 per week for x4 weeks with results brought back to the QAPI committee.	

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F 656	Continued From page 14 R13's care plan noted a focus on activities of daily living (ADL's) because R13 had preferences and other items of need listed in her interventions. Interventions included frequent checks for bed and wheelchair repositioning and comfort initiated 11/10/23, assist of 2 staff for mobility in bed initiated 7/5/21, and assist of one staff for using the toilet with an EZ-Stand dated 7/6/21. R13's care plan included a focus on incontinence/altered elimination with goal of cooperating in establishing a routine for urine elimination. Interventions included R13 is always incontinent of bladder initiated 10/4/21, always incontinent of bowel initiated 7/6/21, assist to and from the toilet initiated 10/17/23, and establish a bladder routine initiated 10/17/23. R13's care plan included a restorative bladder program focus initiated 11/16/23, noting R13 had incontinent episodes related to decreased mobility. Interventions included directing staff to encourage and offer toileting/bedpan upon rising (around 9:00 a.m.), after lunch/before afternoon activities (around 1:30 p.m.), after dinner while getting ready for bed (around 6:30 p.m.) and assist into green overnight pad (incontient briefs), and check resident at midnight and 5:00 a.m. and offer bedpan and change pad initiated 1/30/24 by assistant director of nursing (ADON). R13's care plan included a restorative bowel program focus initiated 11/16/23, noting R13 had increased bowel incontinence episodes related to decreased mobility. Interventions included directing staff to encourage and offer toileting/bedpan upon rising (around 9:00 a.m.), after lunch/before afternoon activities (around	F 656		

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F 656	Continued From page 15 1:30 p.m.), after dinner while getting ready for bed (around 6:30 p.m.) and assist into green overnight pad, and check resident at midnight and 5:00 a.m. and offer bedpan and change pad initiated 1/26/24 by ADON. R13's provider orders included an order dated 3/3/24, directing staff to encourage and offer toileting/bedpan upon rising (around 9:00 a.m.), after lunch/before afternoon activities (around 1:30 p.m.), after dinner while getting ready for bed (around 6:30 p.m.) and assist into green overnight pad, and check resident at midnight and 5:00 a.m. and offer bedpan and change pad to be completed five times daily. R13's nursing assistant care cards direct staff "please must be changed at 7:00 p.m, 12:30 a.m. 5:00 a.m. and 1:30 p.m. daily." The nursing assistant (NA) task charting section of R13's electronic health record (EHR) included toileting. It noted R13 needed to be changed around 9:00 a.m., 1:30 p.m., 7:00 p.m., 12:00 a.m., 5:00 a.m., and as needed, and directed "you need to chart this no matter what. Also notify the nurse." Review of charting for this task from 3/13/24 through 3/26/24 included the following times: 3/13/24 at 5:00 a.m. 3/15/24 at 2:28 a.m., 2:29 a.m., and 11:29 p.m. 3/16/24 at 5:00 a.m. and 10:54 a.m. 3/17/24 at 12:00 a.m. and 5:00 a.m. 3/19/24 at 12:18 a.m. and 5:00 a.m. 3/20/24 at 1:43 p.m., 1:44 p.m., and 11:23 p.m. 3/21/24 at 5:00 a.m. and 11:57 p.m. 3/22/24 at 5:00 a.m., 9:00 a.m., and 1:30 p.m. 3/23/24 at 6:30 p.m. 3/25/24 at 11:47 p.m.	F 656		

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F 656	Continued From page 16 3/26/24 at 5:00 a.m. No other completion times for this task were documented during this time frame. During continuous observation and interview on 3/26/24 at 5:27 a.m., NA-E was observed on the unit, however never entered R13's room. At 7:52 a.m. NA-A and NA-B entered R13's room to complete morning cares. R13 was brought to the toilet with the use of an ez stand mechanical lift and NA-B doffed a white brief with gray sizing lines. NA-A and NA-B reported R13 was last toileted at 5:00 a.m. NA-B reapplied a clean white breif with gray sizing lines. NA-A and NA-B reported R13 only uses white breifs with gray sizing lines. During subsequent observation at 1:40 p.m. on 3/26/24 NA-A and NA-B were observed toileting R13. NA-B reported the last time she was changed was during morning cares and staff are to be changing every two hours and as needed. NA-A reported a toileting time may have been missed due to being very very busy. NA-B reported the brief which was removed was fully saturated and R13 needed to be changed. Email communication dated 03/20/24 at 7:01 a.m., was from family member (FM)-B to DON, ADON, Administrator, nurse manager (NM)-(A) and NM-B and expressed concerns within the last week and noted the following had occurred: "- Monday [3/18/24] got up at 7:55 am not to receive a diaper check or change until 3:45 pm - 8 hours. - Left in bed for 3 hours calling to get out with noone checking her from Tuesday [3/19/24] 1:45 pm - 5:05 pm - never checked on by any staff.	F 656		

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F 656	Continued From page 17 - Placed to bed Tuesday evening [3/19/24] at 7:15 am, no diaper check or reposition until 4:55 am this morning - almost 12 hours. I willl be coming in after work this morning to check on her and expect to have answers as to why her care plan has not been followed and to decide what action needs to be taken. I was told Monday that the care plan was going to be executed which didn't even last one day. We are truly concerned with the level of care being provided in River Bend as a whole with not only mom but other residents as well. We are hoping this sudden change in care for our mom was not reflective of claim filed justifiably with state as we were not the only resident family who filed claims. " During review of FM-B video footage dated 3/20/24, FM-B was in R13's room speaking with the ADON about R13's care.Video footage shows digital clock time of 11:08 a.m. due to outside lighting. FM-B reported video footage showed R13 was put to bed at 7:15 p.m. the night before and staff did not enter the room again until 5:00 a.m. that morning. FM-B reported R13 was never repositioned or checked which usually happened at 12:00 a.m. or 1:00 a.m. FM-B stated this was "totally off" from the care plan. FM-B stated she did not know why staff suddenly failed to follow R13's care plan for toileting and repositioning. FM-B stated this was discussed in a meeting and things had been "solid" since the care plan meeting. FM-B asked the ADON, "All of a sudden are we changing it [care plan] without me knowing?" The ADON replied no. FM-B stated she wanted R13 to be repositioned at night in accordance with the care plan. On 3/26/24 at 7:41 a.m., Tena brand incontinence	F 656		

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F 656	Continued From page 18	F 656		

products, including briefs, were observed in the clean utility room on the Riverbend long term care unit where R13 resided. Briefs included Tena Proskin Stretch Ultra briefs in size medium (purple colored) and large/extra large (tan colored) and Tena Proskin Stretch Super briefs in size medium (green colored) and size large/extra large (green colored). NM-B stated the facility used Tena brand incontinent products, including briefs. The briefs came in different sizes and styles. NM-B identified the green briefs were only for nighttime; the Ultra briefs were for days and the Super/green briefs were for night because they absorbed more liquid.

In an interview on 3/26/24 at 1:04 p.m., NA-B stated R13 only used the gray colored briefs that were in her room. When asked what type of brief R13's care plan directed staff to use, NA-B reported "I don't know, go ask [NA-A]."

During an observation on 3/26/24 at 1:08 p.m., a pack of Tena Proskin Stretch Ultra briefs in size extra extra large (2XL) that were gray colored were noted on the floor next to the cabinet in the private bathroom in R13's room.

In an interview on 3/26/24 at 1:12 p.m., NA-A confirmed the pack of briefs in R13's room were the gray Ultra style briefs. NA-A stated they were for both overnights and days, they were R13's size of 2XL and were the only ones that really fit her and the only ones she used. NA-A noted there was a pack of old ones in the bathroom in size XL, but they didn't fit R13 and staff did not use them. NA-A stated the green overnight pad was different from the one R13 was using. NA-A stated that if a resident's care plan says green pads, it means they needed to specifically wear

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F 656	Continued From page 19	F 656		

that type of pad and there were certain residents who had the green briefs for nighttime use. NA-A reported that staff needed the nighttime briefs because residents weren't checked on as often at night and they held more urine and soaked in more moisture compared to the daytime briefs. NA-A confirmed that R13 was wearing a gray brief and not a green brief when she was changed that morning.

In an interview on 3/26/24 at 1:45 p.m., the ADON and NM-B identified the Bowel and Bladder Data Collection assessment completed by NM--B dated 1/20/24, identified that it included check and change scheduled every two hours or as needed for R13, and reported that facility staff used the care plan as a guide for toileting and the care plan should be followed. NM-B confirmed R13's care plan said she should be using a green overnight brief. When informed of the observations on 3/26/24 of 7:52 a.m. and 1:40 p.m. toileting times, the ADON reported R13 should have been changed before 1:40 p.m. around lunchtime and that toileting time was missed. The ADON stated if a resident missed toileting times it could lead to skin breakdown. The ADON reported according to R13's care plan, staff should be using the green briefs and their purpose was to allow residents to sleep longer because they held more urine. The ADON stated if R13 was not wearing green briefs the moisture-wicking component would be the concern. NM-B stated the green briefs did not come in a 2XL size, they came in a 3XL size but those were too large for R13. NM-B reported the facility had never had the green briefs in size 2XL and the ADON reported he was aware they had green briefs in size 3XL but had not realized the facility did not have size 2XL. The ADON and

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F 656	Continued From page 20 NM-B stated it was staff's responsibility to let management know if they did not have a product available for a resident. The ADON stated it was not his understanding that R13 wearing standard briefs at night would change anything. The ADON stated R13 was to get up at 5:00 a.m., 9:00 a.m., 12:00 a.m., 2:00 p.m. and 7:00 p.m. and was okay going five hours in a standard brief. Facility policy titled Comprehensive Care Plan dated 10/2022, included: "Policy: It is the policy of Volunteers of America to provide a temporary care plan within 48 hours of admission (Admission Individual Care Plan) and a complete person centered and comprehensive care plan by the resident's 21st day of admission. The care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible consistent with resident rights. Procedure: 5.) This comprehensive care plan will have problem/strength statements, measureable goal statements, treatment preferences and interventions. The care plan will be written in a culturally competent manner recognizing the patient's diverse values, beliefs, and behaviors, including tailoring delivery to meet patient's social, cultural, and linguistic needs. 9.) Interventions should be written to help meet the resident's goal. The intervention should be individualized to the resident and Kardexed to update the resident's individual care planned needs."	F 656		
F 686 SS=G	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	F 686		4/25/24

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F 686	Continued From page 21 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 record review the facility failed to ensure comprehensive assessments were consistently completed, provide and implement interventions to prevent recurrent pressure ulcers (PU) for 1 of 1 residents (R13) who had a history of facility acquired stage 3 pressure ulcers. The facility's failures resulted in actual harm when R13 developed a recurrent pressure ulcer to the right heel. Findings include: R13's significant change Minimum Data Set (MDS) dated 1/23/24, indicated R13 was admitted to the facility on 9/23/23 with diagnoses including aphasia following intracranial hemorrhage (difficulty understanding or expressing speech following a brain bleed), morbid obesity, muscle weakness, heart failure, diabetes mellitus, non-Alzheimer's dementia, and arthritis. R13 required maximal assistance with mobility in bed and was dependent on staff for sitting up, lying down, and transfers. The MDS identified R13 as at risk of developing pressure ulcers/injuries with three current stage 3 pressure ulcers which were not present upon	F 686	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R-13 Comprehensive skin assessment completed. A new intervention immediately implemented with use of a heel manager. Care plan updated regarding the use of heel manager to ensure offloading to heels occurs, and turning / repositioning to prevent recurrent pressure injuries. New Braden scale and skin risk data collection was completed. Will continue monitoring at least weekly to assure skin integrity is being observed and monitored. Nursing weekly 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. 67 of 117 residents have been identified to be at risk for pressure injuries and could be affected. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.	

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F 686	Continued From page 22 admission/entry or reentry. Treatments included pressure reducing device for chair, pressure reducing device for bed, application of ointments/medications other than to feet, and pressure ulcer/injury care. MDS did not identify R13 required a turning/repositioning program. R13's MDS dated 10/12/23, included the last Brief Interview for Mental Status (BIMS) completed, with a score of 3 indicating severe cognitive impairment. R13's orders included a physician order dated 1/16/24, "ensure resident is being turned and repositioned frequently due to wounds every evening and night shift." R13's wound physician note dated 1/17/24, noted R13 was referred for a wound care assessment and evaluation and had wounds on her right heel, left coccyx, and right buttock. The wounds were identified as a stage 3 pressure wound of the right heel full thickness, stage 3 pressure wound of the left coccyx full thickness, and stage 3 pressure wound of the right buttock full thickness. Treatment recommendations included floating heels in bed (positioning to keep heel up and not in contact with bed to avoid putting pressure on the area), off-loading the wound (minimizing weight bearing on the affected foot), repositioning per facility protocol, and using a low air loss mattress. Review of R13's record between 1/17/24 and 3/25/24 identified the the left coccyx wound and the right buttock wound were resolved or healed on 2/21/24. The record identified the right heel wound was resolved on 2/24/24, however two days later on 2/26/24 a stage 2 PU had developed on right heel. On 3/11/24 and on	F 686	a Policies/procedures were reviewed and continue to be current b. Comprehensive assessments will be completed per policy. Care plans will be developed with individualized interventions. Weekly monitoring of skin integrity will be completed. The care plan for skin integrity will be reviewed and revised based on response, outcomes, and needs of the resident. b. Residents at risk of pressure injuries will continue to be assessed upon admission for skin integrity and care planned to promote prevention of pressure injuries c. Education on pressure injury prevention and treatment to clinical staff. Also ensure all interventions are care planned for residents with a history of pressure injury along with turning and repositioning education. Education provided 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. Using the audit tool, the DON or designee will conduct random audits of comprehensive assessments to ensure interventions are in place on the care plan as well as at the bedside to reduce the risk of pressure ulcers. x5 per week for x4 weeks with results brought back to the QAPI committee.	

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F 686	Continued From page 23 3/25/24 the record indicated the wound had resolved, however by 3/26/24, another pressure ulcer on R13's right heel had developed. Record of R13's right heel wound included the following: R13's physician order dated 1/18/24 (with no stop date), instructed staff to "cleanse right heel with normal saline and pat dry. Apply skin prep to surrounding skin, Xeroform [a gauze wound dressing impregnated with petroleum] to wound bed and cover with gauze island" every day shift. R13's physician order dated 1/26/24 instructed, "at these times, you need to ensure that her heels are floating on a pillow, and she is also turned. She prefers to have pillow on her (R) [right] buttock side due to her wound. Family is reviewing her video camera daily and reporting back to the facility" three times daily at 12:00 a.m., 5:00 a.m., and 7:00 p.m. R13's care plan with review date of 2/2/24, included skin as a focus area related to a history of right heel pressure injury. Current interventions included a pressure-reducing mattress on R13's bed and wheelchair (1/18/24), assisting as needed with repositioning while sitting and lying as R13 was unable to reposition self initiated (4/20/23), inspecting skin daily with cares and nursing assistants (NAs) reporting concerns to the nurse (10/4/21), floating the right heel and applying skin prep [protective skin barrier applied with wipes that helps to reduce friction on skin] per orders (initiated 10/4/21), and weekly skin assessments by licensed nurses (initiated 7/25/23). R13's electronic health record (EHR) included additional wound care notes from wound	F 686		

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F 686	Continued From page 24 physician visits on 1/23/24, 1/31/24, and 2/7/24 that included comprehensive assessments of R13's heel wound. The note dated 2/21/24 did not include assessments of R13's wounds and documented "Signing off on patient who remains in the facility. Per facility wound care is being transferred to [name of agency]. Sign off without visit." R13's wound physician note dated 2/7/24, noted R13 had a stage 3 pressure wound of the right heel full thickness measuring 0.25 square centimeters (cm) in area/0.5 cm long/0.5 cm wide/0.1 cm deep with light serous exudate (clear thin discharge), 30% thick adherent devitalized necrotic tissue, 70% other viable tissues, and was improved R13's Skin and Wound Evaluation dated 2/21/24, R13's right heel wound was not addressed on 2/21/24 along with the other wounds. R13's Nursing Weekly Skin Check dated 2/24/24, indicated she had pressure wounds that were not new. Comments noted R13's heel was healed but a dressing was still applied to protect the newly fragile area. No further description of the heel wound was included. R13's Skin and Wound Evaluation dated 2/26/24, noted a stage 2 pressure wound on R13's right heel that was acquired at the facility, present for between one and three months, measured less than 0.1 square cm in area/0.4 cm in length/0.2 cm wide, had a wound bed 100% filled with granulation tissue, was staged by a healthcare provider, did not have evidence of an infection, had a scab present, no drainage, no odor, attached edges between the wound and	F 686		

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F 686	Continued From page 25 surrounding skin, scarring of tissue surrounding the wound without hardening or swelling that was a normal temperature, no wound pain, and the dressing was intact. Additional cares were none, a heel suspension/protection device or turning/repositioning program were not identified. The progress of the wound was marked as improving. This was the first comprehensive assessment of R13's heel wound noted in records since the wound physician visit on 2/7/24. R13's Nursing Weekly Skin Check dated 3/3/24, indicated she had an "other" skin issue that was not new. Comments noted R13's right heel wound was improving with treatment in place. The documentation did not include further description of R13's right heel wound. R13's Skin and Wound Evaluation dated 3/4/24, noted a stage 2 pressure wound on R13's right heel that was acquired at the facility, present for between one and three months, measured 0.2 square cm in area/0.5 cm long/0.4 cm wide, had a wound bed 60% covered with epithelial tissue and 40% covered with granulation tissue, was staged by a healthcare provider, did not have evidence of infection, had a scab present, no drainage, no odor, attached edges between the wound and surrounding skin, unbroken/intact skin surrounding the wound without hardening or swelling that was a normal temperature, and no wound pain. The assessment indicated the tissue surrounding the wound was not reddened. The dressing was intact and treatment included additional cares of a heel suspension/protection device. The progress of the wound was marked as improving. R13's Nursing Weekly Skin Check dated 3/6/24,	F 686		

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indicated she had an "other" skin issue that was not new. Comments noted "no new skin concern currently." No further description of the heel wound was included.

R13's Nursing Weekly Skin Check dated 3/9/24, indicated she had both an "other" skin issue and "none identified/no skin issues found" that were not new. Comments indicated no new skin concerns were noted, R13's right heel wound was improving with treatment in place. No further description of the heel wound was included.

R13's Skin and Wound Evaluation dated 3/11/24, noted a stage 3 pressure wound on R13's right heel that was acquired at the facility, present for between one and three months, had an intact surface (was not an open wound), was staged by a healthcare provider, did not have evidence of infection, had a scab present, no drainage, no odor, attached edges between the wound and surrounding skin, unbroken/intact skin surrounding the wound without hardening or swelling that was a normal temperature, and no wound pain. The assessment indicated the tissue surrounding the wound was not reddened. The treatment included additional cares of repositioning devices and a turning/repositioning program. The progress of the wound was marked as resolved. The wound measurement section was blank.

R13's Nursing Weekly Skin Check dated 3/13/24, noted no skin issues were identified or found.

Email communication dated 03/20/24 at 7:01 a.m., was from family member (FM)-B to DON, ADON, Administrator, nurse manager (NM)-(A) and NM-B and expressed concerns within the last

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F 686	Continued From page 27 week and noted the following had occurred: "- Monday [3/18/24] got up at 7:55 am not to receive a diaper check or change until 3:45 pm - 8 hours. - Left in bed for 3 hours calling to get out with no one checking her from Tuesday [3/19/24] 1:45 pm - 5:05 pm - never checked on by any staff. - Placed to bed Tuesday evening [3/19/24] at 7:15 pm, no diaper check or reposition until 4:55 am this morning - almost 12 hours. I willl be coming in after work this morning to check on her and expect to have answers as to why her care plan has not been followed and to decide what action needs to be taken. I was told Monday that the care plan was going to be executed which didn't even last one day. We are truly concerned with the level of care being provided in River Bend as a whole with not only mom but other residents as well. We are hoping this sudden change in care for our mom was not reflective of claim filed justifiably with state as we were not the only resident family who filed claims. " R13's Nursing Weekly Skin Check dated 3/24/24, noted the presence of a scar that was not a new skin injury. It lacked further details about the scar and did not include information related to R13's heel wound. R13's progress note dated 3/25/24, indicated that, regarding completion of the 1/18/24 order for right heel wound care, it was "healed per nurse manager." R13's Point of Care task for turning and reposition instructed direct care staff "at these times you need to ensure that her heels are floating on a pillow, and she is also turned. She	F 686		

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prefers to have pilow on her (R) buttock side due to her wound. Family is reviewing her video camera daily and reporting back to the facility.With a look back of 14 days identifed "no data found'.

During continuous observation on 3/26/24 from 5:27 a.m. to 7:52 a.m., R13 was noted to be lying directly on her back in bed with blanket over her body. R13's legs at the same height on top of the bed with toes pointed upward, one leg was not higher than the other. Staff did not enter the room to offer to turn or reposition R13 during this time. At 7:52 a.m., nursing assistant (NA)-A and NA-B entered R13's room. R13 had a "turn me frequently" sign above her bed. When NA-A pulled back the blanket both of R13's heels were positioned directly on the mattress. NA-A reported R13's heels were not supposed to be lying directly on the bed and were supposed to have a pillow underneath them. NA-A identified a pillow to the side of R13's leg in bed and reported the pillow should be under R13's right leg. NA-A reported R13 did not have heel protectors or anything else to prevent contact between R13's heels and the bed. At 8:07 a.m., R13 stated "owweee" when NA-B put on her right sock. NA-A and NA-B did not respond to R13's report of discomfort.

During an interview on 3/26/24 at 8:47 a.m., NA-A reported R13 was last turned and repositioned around 5:00 a.m. and staff were to document this in the electronic charting system, including if a resident refuses care. NA-A stated staff should not go longer than three to four hours between turning and repositioning residents but for R13 anything longer than two hours was too long. NA-A stated overnight staff were responsible for

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F 686	Continued From page 29 ensuring R13's heels were floated while she was in bed. During an interview on 3/27/24 at 11:13 a.m., NA-E reported to be R13's overnight NA from 3/25/24 to 3/26/24. NA-E stated she/he checked/changed and repositioned R13 at 12:00 a.m. and then again at around 4:40 a.m. NA-E indicated a pillow had been placed under R13's right heel. During observation on 3/26/24 at 1:21 p.m., R13's feet were examined with clinical manager (CM)-B. R13's socks were removed and feet were bare with no dressings or coverings in accordance with active physician orders. R13's right heel was noted to have a small intact scab approximately ¼" x ¼" in the middle of the backside of the heel with an area of generalized redness extending around the scab approximately 1" above and to the sides and 1 ½" below extending to the bottom side of the foot that blanched (turned white) when pressed. To the left and right of the scab were areas of darker redness, both approximately ¼" x ¼" that did not blanch when touched. The left heel had generalized blanchable redness extending across the back of the heel and onto the bottom surface and sides of the foot approximately 3" x 3". CM-B gently pressed on R13's heels and indicated the tissue on both heels was boggy (tissue that has a spongy or mushy quality when pressed) to touch. During an interview on 3/26/24 at 1:36 p.m., clinical manager (CM)-B stated there was redness on both of R13's heels and they were "boggy" to the touch. CM-B noted the areas of darker redness next to the scab on R13's right heel and noted the generalized redness to be	F 686		

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F 686	Continued From page 30 blanchable. CM-B did not remark on the non-blanchable areas that had been identified. CM-B stated the redness was concerning because "it will get worse". CM-B stated the redness on the left heel was a new issue. CM-B stated there was concern for stage 1 pressure injuries on both heels. During a subsequent interview on 3/26/24 at 2:01 p.m., CM-B stated R13's care plan identifies she has a history of a pressure injury on the right heel with related interventions that included floating the right heel and applying skin prep. CM-B noted R13's heel should be floated to relieve pressure so the skin doesn't break down further. CM-B confirmed that someone with a history of a pressure injury on their heel would be at increased risk of developing another pressure injury in that area. In an interview on 3/26/24 at 3:30 p.m., director of nursing (DON) reviewed a photograph of R13's right heel taken at 1:37 p.m. during examination with CM-B. The DON stated it was something he would note and document when completing a skin check. He described R13's heel as a scab with an unstageable wound base because the wound base was not visible so he could not determine if it was eschar [dead tissue] or just not clean. The DON described the skin surrounding the scab as "darker in pigment" and intact. In review of a photograph of R13's left heel taken at 1:37 p.m., the DON described the left heel as intact without further comment. The DON stated R13 had a history of pressure wounds on her bottom and right heel, previously up to stage 3 wounds. The DON confirmed R13's care plan directed staff to float her right heel and use skin prep and perform weekly nursing skin	F 686		

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F 686	Continued From page 31 assessments with the expectation that the heel be floated when R13 was in bed. The DON confirmed that the Nursing Weekly Skin Check completed two days prior on 3/24/24 did not include any documentation of skin issues or concerns related to R13's heels. The DON stated he would "100% expect" to see documentation of R13's right heel on the skin assessments and the lack of documentation on the assessment was "unacceptable." The DON stated staff did weekly skin checks and reported issues. The facility's provider doctor of medicine (MD)-A was monitoring R13's heels weekly and "I am looking to see if he has anything in his notes right now, I don't see anything in his note." The DON stated the facility needed to work on their communication among staff, ensure R13's heels were floated, DON also stated R13's assessments needed to be accurate, the care plan needed to be accurate, and all staff should be following the care plan for R13. Facility Policy titled Prevention and Treatment of Pressure Ulcers/Pressure Injury dated 11/22/22 included: "B.) Nursing: Monitoring of Skin Integrity: Skin will be observed daily with cares by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse; Weekly skin audits will be performed by the Licensed Nurse (Refer to Body Audit Policy and Procedure). An alert will trigger from question B of the assessment to the clinical dashboard that will notify the IDT that a new skin issue has occurred and follow up is needed; If a dressing is ordered, it will be monitored for appropriate placement on resident; If a skin concern is noted, refer to section II. Treatment of Pressure Ulcers	F 686		

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F 686	Continued From page 32 and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed) procedure and Wound Care Protocols. C.) Turning and Repositioning Observation (tissue tolerance): Pressure is the primary cause of pressure ulcers. An effective turning and repositioning schedule can help reduce the risk of developing a pressure ulcer. Everyone's ability of their skin and its supporting structures to endure the effects of pressure without breakdown, is different. Therefore, it is important to individualize each resident's turning and repositioning schedule based on abilities and needs." II.) Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed)If a resident is admitted with or there is a new development of a pressure ulcer or lower extremity ulcer the following procedure is to be implemented: (8) Update the residents individualized Care Plan for Skin Integrity and nursing assistant Kardex with any skin concerns and interventions. Include appropriate risk factors, turning intervals and interventions as appropriate. (9) Initiate Weekly Wound Documentation to be completed every seven days and PRN in electronic health record which will include: type of wound, location, date, stage (pressure ulcers only) or indicate partial or full-thickness (arterial, venous, neuropathy/diabetic ulcers), length, width and depth; wound base description, wound edge description and if present: drainage, odor, undermining, tunneling, and/or pain. The Weekly Wound Documentation Progress Form should only have ONE WOUND per form. See Weekly Wound Documentation Progress Sheet & Wound	F 686		

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F 686	Continued From page 33 Documentation Guidelines for instructions. (10)When a wound is present, daily wound monitoring should include: An evaluation of the wound, if no dressing is present; An evaluation of the status of the dressing, if present; The status of the area surrounding the ulcer/wound (that can be observed without removing the dressing); The presence of possible complications, such as signs of infections; Whether pain, if present, is being adequately controlled; Document on any changes or concerns in the nurses notes and re-evaluate prior steps 1-9 as appropriate."	F 686		
F 689 SS=D	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 use mechanical standing lifts in accordance with manufacturer recommendations for 2 of 3 residents (R1, R13) reviewed for accidents. Additionally, failed to ensure the wander-guard system was operational to prevent elopement for 3 of 4 residents (R9, R14, R12) reviewed for elopement. Findings include: MECHANICAL LIFTS and COMMODE	F 689	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R1 commode removed from the floor, fixed and returned to resident. b. Immediate review of care plans and care sheets for accuracy of sling size. Staff that provide cares to R1 and R13 have been educated on where in the care sheet the color of the sling is located. c. Replaced and disposed of low battery wander guard tags with new fully charged	4/25/24

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F 689	Continued From page 34 R1's face sheet identified R1 had diagnoses including multiple sclerosis (MS), vascular dementia, and hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stoke) affecting right dominate side. R1's quarterly Minimum Data Set (MDS) dated 2/16/24, identified R1 was cognitively intact and required substantial/maximal assist to roll left and right and move from sitting to lying or lying to sitting. R1's care plan dated 6/2/23, identified R1 had activity of daily living (ADL) self-care performance deficits due to MS with right sided weakness requiring extensive assist for most cares.R1 required an EZ-Stand with two staff assist for all other [outside of getting in and out of bed] transfers. Staff were to double loop per patient preference, and sling size large- burgundy. Please be aware of placement of my hand when buckling the harness to avoid pinching skin. R1's nursing assistant (NA) care guide dated 3/8/24 identified R1 required the use of an EZ-stand lift with assist of two staff and sling [harness] size large. During interview on 3/21/24 at 9:30 a.m., family member FM-(A) expressed concerns regarding the way staff were transferring R1 with the use of the mechanical lift as it did not appear staff were using it correctly. FM-A had observed R1 hanging in the lift and was fearful R1 would slide through the harness. Additionally, FM-A reported concerns with R1 attempting to reach things such as her call light and leaning while seated on commode.	F 689	tags for R9, R12 and R14. d. Vendor for wander guard doors called immediately and the sensor range of the Wander guard doors fixed and range expanded to reach all areas. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. 6 of 117 residents use commodes and could have the potential to be affected b. 32 of 117 residents who use lifts have the potential to be affected c. 3 of 118 residents who use wander guards are at risk to be affected 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. Clinical staff re-educated on reviewing care plans for accuracy of resident□s sling size for use of EZ stand. b. Clinical staff re-educated on not leaving resident alone on commode in EZ stand unless on care plan. c. Clinical staff re-educated on resident identifiers that meet the criteria for EZ stand use. d. Clinical staff re-educated on immediate reporting to nurse if resident has a change of condition that may affect safe use of EZ stand. e. Clinical staff educated on correct Hoyer sling placement. f. Clinical staff re-educated on observing resident□s verbal and non-verbal cues while using the mechanical lift. g. Staff to be re-educated on immediate removal/replacement and proper reporting of potentially faulty equipment.	

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F 689	Continued From page 35 During interview on 3/22/24 at 10:31 a.m., NA-D reported staff could not leave R1 alone on the commode due to safety. R1 didn't typically keep her body position upright and always leaned to her right. If R1 was in the lift and started to get tired she would let you know. At that point, the transfer needed to be stopped and R1 needed to be sat back down. R1 could fall if she got too tired. NA-D reported R1 used a large red [burgundy] harness. R1 required the lower leg strap and to make sure the harness was tight. R1 required 1 black loop connected from the harness to the EZ stand to support R1's upright position staff are to not use more then one loop at a time. If there was ever a concern with equipment, facility staff needed to remove it from the unit immediately and notify maintenance. R1's weight dated 3/21/24, identified R1 to be 212.8 pounds (lbs). During observation of video camera footage dated 3/20/24, R1 was noted to be seated on a bariatric drop arm commode unsupervised while attached to a mechanical EZ-stand lift. R1's upper body was leaning and up against the right side with her right arm dangling supported by arm rest of the commode. R1 was attempting to reach the call light located on her right pant leg requiring R1 to reach toward her hemiparetic side down towards her knee and appeared to be struggling to reach the call light. R1's lower leg strap was not applied when staff entered room and progressed with transfer off the commode. During observation on 3/21/24 at 1:13 p.m., R1 was transferred from wheelchair to commode with use of mechanical EZ stand lift by NA-B and NA-C. The lift's calf/leg safety strap had	F 689	h. Nursing staff educated on process of checking battery status of wander guards and will be checked weekly by whom? . 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. Using the audit tool, the DON or designee will conduct random audits of resident rooms to ensure commodes are functional and the legs are all set to the same height x1 per week for x4 weeks with results brought back to the QAPI committee. b. Using the audit tool, the DON or designee will conduct random audits to ensure proper sling sizes are being used per resident□s weight x1 per week for x4 weeks with results brought back to the QAPI committee. c. Using the audit tool, the Maintenance Director or designee will conduct random audits of the wander guard tags to ensure the tag does not have a low battery x1 per week for x4 weeks with results brought back to the QAPI committee. d. Using the audit tool, the Maintenance Director or designee will conduct random audits of the wander guard doors to ensure the sensors are working and mag locks engage when tag nears the doors x1 per week for x4 weeks with results brought back to the QAPI committee.	

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F 689	Continued From page 36 significant slackl NA's were altered by the surveyor, NA's then cinched the strap so it was snug. NA's applied a green harness around R1's back and connected the harness by double looping the hooks on the lift. Once R1 came to a standing position the upper belt was not tightened also causing significant slack in the support harness positioning. Once R1 was seated, R1 was leaning to right side on the commode while attached to the lift. NA-B and NA-C directed R1 to call for help when done toileting and left R1's room leaving her unattended on the commode attached to the lift. Once NA's reentered the room, NA's changed the double to a single black loop. When the NA's started raising R1 off the commode, R1's hemiparetic arm was pressed between the side of the commode and her body, NA's did not stop raising R1 until the surveyor alerted the NA's of R1's position. After R1 was correctly positioned and lifted off the commode the commode became off balance and started tipping. Once R1 was in a standing position in the lift R1 was only hanging onto the lift with her left hand, the right arm hung down at her side. NA-B walked away from R1 to get gloves while NA-C gathered incontinent supplies. R1 began to "sink" or slouch from an upright position so that R1's bottom was parallel with the floor and appeared to be dangling in the harness. R1 demonstrated labored breathing and stated "I am getting really tired". R1 had labored breathing and inability to stand upright. Even though NA's were alerted to R1's fatigue and positioning in the lift, NA's continued to provide incontinent cares and put on R1's brief. By the time cares were completed, R1's right shoulder was up and over her right ear and the back of the harness was up to the level of her neck instead of the middle of her back causing R1's neck to become in a	F 689		

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F 689	Continued From page 37 forward/crouched position due to the harness pressure on her neck. During interview and observation on 3/21/24 at 1:30 p.m., NA-B and NA-C stated commode was not balanced and identified the right rear commode leg was not in the metal support bracket, the right front was on the second bracket with the left front and left back were on the third bracket. Due to height setting discrepancy the commode had approximate 2.5" height difference causing the commode to be unstable and tip when weight was applied to it. NA-B and NA-C reported commodes were not supposed to tip or move like that. Even after the NA's identified the commode was unstable, NA-B cleaned the commode and placed it back into the general storage area for subsequent use. During interview on 3/21/24 at 1:27 p.m., NA-B reported she was in charge of the set up of the transfer and NA-C was the driver of the lift. NA-B explained the waist strap of the harness should be tightened as a resident comes to a standing position but forgot to do so during the transfer. NA-B also reported the leg straps need to be tightened for support and felt R1's legs were good and supported once it was tightened. NA-B stated R1 was to use the green XL harness and pointed to the coloring on the harness which was also green and what they used during the transfer. R1 was to only have 1 of loop of the harness used to connect to the lift on each side, but some people used two loops depending on their weight and identified it was corrected during the transfer of going from the commode to the recliner. NA-B was unable to identify R1's fatigue level and explained "it was normal" for R1 "to hang in the lift" because R1's right arm did not work. NA-B	F 689		

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F 689	Continued From page 38 stated R1 was okay to leave on the commode while hooked up to the EZ stand and R1 would use the call light when she was done. The EZ-way Harness manufacturer's color coding system identified a green harness as an extra large for people between 280 and 450 lbs. The large harness is burgundy and for people between 190 and 320 lbs. Per manufacturer guidelines, a large burgundy size harness was appropriate for R1. During interview on 3/21/24 at 2:15 p.m., NA-C reported R1 required assist of two staff for the mechanical EZ stand and R1 used the green size harness and thought that was what should be on the care plan. If nursing assistants had questions about the care plan, they would log in to the computer and see it. NA-C was not sure if the facility had care cards/guides. NA-C reported both loops were connected to the lift due to R1's preference. NA-C reported most residents require one harness loop, but was not sure about the rules for only needing one loop. NA-C reported seeing R1 starting to sink and would usually put R1 down in a seated position to provide a rest, however did not due to NA-B needing to complete peri care tasks. NA-C identified if they would have kept going R1 would have fallen from the lift. NA-C reported R1's right arm always hung and did not notice R1's arm was caught upon coming up to a standing position until intervention was provided. NA-C reported both the upper straps and lower straps should have been tighter. During interview on 3/21/24 at 3:41 p.m., director of maintenance DM-(A) reported no maintenance requests had been made regarding a commode. During review of the commode, DM-A identified	F 689		

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F 689	Continued From page 39 the commode leg setting was not engaged in the metal bracket and the legs were not set evenly. DM-A reported the commode should not be in general use in its current condition. The appropriate process was for staff to immediately remove it from the floor due to the risk of someone using equipment that needs attention. DM-A stated if a resident used the commode in the situation observed, the resident would be at a high risk of falling and "cracking their head". During interview at 3/21/24 at 3:50 p.m., nurse manager NM-(A) reported she had been notified about the commode and was planning on going to check on it. NM-A had not because of shift change and was telling staff about the commode, however had not checked on it yet or pulled it from general storage area for subsequent use. During interview on 3/22/24 at 10:39 a.m., licensed practical nurse LPN-(A) reported staff should never leave R1 alone while attached to the lift due to the risk for R1 falling or tipping which could lead to injury or death. LPN-A reported staff should follow the resident safety and supervision guidelines and gestured to the resident safety and supervision guidelines located on the wall. LPN-A reported deserving R1 transfer and expressed concerns of R1's positioning due to heavy leaning from her hemiparesis and inability to support body on the right side and R1 leans very far to the right side and could fall. Staff were to use the harness that was directed by the care cards and care plans. If there was ever a concern with equipment it should be removed from the unit immediately and reported to maintenance. Employee notification instruction sheet titled Resident Safety and Supervision, undated	F 689		

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F 689	Continued From page 40 located on nursing station wall. Related to Resident Position and Mechanical Lifts directs staff to never leave a resident in a potentially unsafe position. Always consider the residents cognition, condition, fall risk/fall history when determining when it's appropriate to leave the resident unattended. Residents must not be left unattended when attached to mechanical lifts such as EZ Stand or EZ Lift (Hoyer). Including when seated on the toilet. Remember to check the care plan and care guide for information on resident's risks for falls and fall interventions. During interview on 3/25/24 at 10:46 a.m. NOVA heavy duty drop-arm commode manufactures representative MR-(A) reported it was very important to use bariatric drop arm commodes properly and misuse could cause a safety concern or fall. The metal brackets need to be secured in place and checked prior to use to avoid the product being unlevel. Using the product on different leg adjustments could lead to injury or falls. The commode was not to be used while attached to any sort of mechanical lift unsupervised as a person should have their feet flat on the ground and knees at a right angle and a resident should be able to maintain an upright sitting position. The arms of bariatric drop arm commodes were not meant to support body weight and could give way if a resident applied excessive pressure to it. Nova heavy duty drop-arm commode item #8583 manufacturer recommendations identified the legs must be adjusted to same height (number) so the commode sits level. Make sure legs and backrest are secure (push button locked completely into hole) before using. Check before each use. Use on a level surface.	F 689		

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F 689	Continued From page 41 Equipment repair policy dated 5/18/23 identified inoperative or malfunctioning equipment shall be promptly reported, in writing, to the maintenance department via the repair required for or TELS (electronic maintenance system). Conditions which warrant immediate attention must be verbally communicated to the maintenance director or designee as soon as the condition is discovered, to ensure prompt resolution. R13's face sheet identified diagnoses including aphasia following intracranial hemorrhage (difficulty understanding or expressing speech following a brain bleed), morbid (severe) obesity, muscle weakness, and vascular dementia. R13's significant change Minimum Data Set (MDS) dated 1/23/24, R13 required maximal assistance with mobility in bed and was dependent on staff for sitting up, lying down, and transfers. R13 was dependent for toileting hygiene R13's MDS dated 10/12/23, included the last Brief Interview for Mental Status (BIMS) completed, with a score of 3 indicating severe cognitive impairment. R13's nursing assistant care guide identified R13 required the use of an EZ-stand transfer with assist of one. Harness size was not identified. During a returned call on 3/27/24 10:16 a.m., FM-B reported she was R13's power of attorney due to R13 being unable to make her needs known. FM-B reported installing a camera system	F 689		

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F 689	Continued From page 42 in R13's room to oversee R13's cares when FM-B could not be physically present. FM-B reported ongoing issues and provided video camera footage to the ADON, director of nursing, and administrator and wrote grievances to management including a grievance from 11/17/23 and ongoing lack of safety since with the use of mechanical lifts. FM-B reported emailing facility staff about a concern with a transfer which happened on 3/20/24 as it appeared the transfer was not completed properly and was causing R13 pain. FM-B expressed R13 appeared to be dangling and not hooked up appropriately and fearful R13 could have fallen from the lift. FM-B reported the concern to be ongoing as there had been situations FM-B observed staff not clasping straps or using mechanical lifts correctly. FM-B reported no facility staff connected with her regarding this email on 3/20/24 outside of the initial response. Grievance with a date of occurrence on 11/17/23 from FM-B regarding R13 identified FM-B called director of nursing (DON) on 11/20/23 with concerns about her mothers left hand having trauma related injury from a EZ-stand transfer [which happened on 11/17/23].FM-B was concerned that during an EZ stand transfer, her mothers hand placement was an issue and caused R13 discomfort in her left hand. An x-ray was ordered and negative for a fracture. Her left hand appears with mild swelling and is receiving ice. FM-A requested the nursing staff to be educated on R13's transfer status and how to properly stand with the EZ stand. Summary of investigation completed by DON on 11/21/23. included reviewing nursing assistant assignment board and video camera with FM-B. Interviewed and educated nursing staff , nursing management	F 689		

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F 689	Continued From page 43 and interdisciplinary team (IDT). Resident had been downgraded to the use of a Hoyer lift with assist of two staff. Email communication on 3/20/24 at 7:01 a.m., from FM-B to administrator, DON, assistant director of nursing (ADON) and NM-A and NM-B included "They were having trouble to get mom to bed and it was 10 p.m. so I told them to use the lift [fully body mechanical hoyer lift] I pulled up video and was disturbed to find she [R13] wasn't hooked up correctly the first time and was pulled her awkwardly causing her pain. They had to bring her back down and correctly fix the straps. Video is attached.".FM-B received a response on 3/20/24 at 8:49 a.m., from DON "Hi [FM-B], please let us know when you will be in today so we can talk. Thanks" Video image attached to the email 3/20/24 at 7:01 a.m., showed R13 seated in a wheelchair in her bedroom. Two female facility staff members enter room with a full body mechanical lift. Staff members applied the full body sling behind R13. Staff members did not apply the back side of the sling under R13's tail bone. R1's lower straps were crossed under R13's legs. Staff then applied the shoulder straps appropriately to the lift. Upon attaching the lower leg straps to the lift, the left leg strap is twisted and under R13's leg near knee and not under her thigh or hips. R13 was visualized screaming and crying "oww" "ouch" "oh my god" and grimacing as the lift continued to cause ongoing pressure in the rising position. Facility staff members told R13 "it's okay calm yourself" as R13 continued to sink lower through the hole of the sling. As tension is applied to the lift to raise R13 up from the wheelchair R13 became in a V like position Facility staff then start	F 689		

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F 689	Continued From page 44 lowering R13 back to the wheelchair and at 0:03:09 it was visualized that the left leg support is noted to be under R13's knee and twisted. R13's legs were in an uneven position. R13 continued to call out in pain as staff attempted to reposition the sling. Video footage ends prior to a complete and safe transfer. EZ-way regular sling operator instructions for a full body mechanical lift for transferring a patient from chair, wheelchair or toilet direct staff to do the following. To set the sling properly, you must do the following: on the patients right side, position your hand between the patients hip and the sling. With your fingers push down on the edge of the sling so it touches the base of the chair seet. Next, grasp the bottom edge of the sling leg with your left hand and pull with a tug towards you. Lift the patients left knee and with a tug, pull the leg of the sling under the hip and thigh. Staff are to repeat procedure on the right size. This procedure will ensure the sling is under the patient's tail bone and behind his/her back, with the patients weight evenly distributed on the sling. Note: make sure all seams of the sling are smooth underneath patient. During observation of video camera footage from 3/20/24 at 1:10 p.m.,R13 was using a sit to stand EZ-Stand Mechanical lift. R13's harness strap was not at her waist and was at breast level and not tight to R13's chest. When staff asked if R13 was okay she shook her head no, staff did not respond to R13's non verbal expression. Staff did not apply the lower leg strap to R1's lower extremities. The driver of the lift did not identify the reason the lift was not moving was due to a call light cord on the ground. The driver of the machine attempted to push over the cord before	F 689		

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F 689	Continued From page 45 the second helper intervened and corrected it. EZ way manufacturer instructions for the the EZ-Stand mechanical lift harness directed for the harness to be positioned around the upper body so the sides of the harness are between the patients torso and arm, resting two to three inches below the underarm. For the safety of the patient securely fasten the safety strap around the patients torso. Secure the buckle and pull the straps to tighten. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. Use of shin pad strap: if a caregiver deems it necessary to keep a patients shins or feet on the foot plate, secure the shin strap around the patients legs. During observation and interview on 3/26/24 at 8:12 a.m., NA-A and NA-B assisted R13 to a sitting position on the edge of the bed however R13 was not sitting straight and leaned to one side. NA-B applied the EZ stand harness and attached it to the lift, however because R1 was leaning and not centered on the edge of the bed, R13's feet were not touching the platform of the lift . Chest strap was applied and NA-B reported "okay we are going up". The calf strap was not applied until the surveyor questioned if it was supposed to be, NA-B indicated she forgot it and did not identify R13's feet were not on top of the platform. Again the surveyor questioned NA's if R13's positioning on the lift was appropriate. NA-B then corrected R13's position by moving her feet forward onto the platform of the lift NA-B and NA-A reported the lower strap should be applied prior to transferring and a resident's feet should be on the platform. During interview on 3/21/24 at 1:27 p.m., NA-B	F 689		

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F 689	Continued From page 46 reported when using EZ- Stand lifts when you apply the chest harness to a resident the strap should be tightened and if it came loose while standing it should be tightened again. Lower leg straps should be applied for residents and also be tightened. The foot plate on the EZ-stand should be where the resident's feet were before standing. During interview on 3/26/24 at 8:47 a.m., NA-A reported being the nursing assistant for R13 this day and reported the strap should have been added and R13's feet should have been on the platform prior to keep going with the transfer. During interview on 3/22/24 at 11:18 a.m., director of nursing (DON) reviewed video footage 3/11/2024 through 3/20/2024 of R1 in the EZ stand with nursing staff. DON reported concerns of R1 in a hanging position, the upper belt not being tightened upon standing and R1's level of assist needs to clarified and reassessed. In reviewing video footage from 3/20/24 DON reported R1 should not leaning over the side of the commode as R1 is at a high risk for falls in the observed position. With R1's arm dangling and being transferred improperly this could result in injury to R1. The expectation with improperly working equipment is that it is pulled from use immediately. DON reported identifying concerns regarding the EZ stand and residents should be able to an upright position and the straps should be applied for both the harness and the lower legs. Nursing assistants need to know how to identify when transfers are inappropriate and notify a nurse. Staff need to recognize safety concerns, stop and readjust when residents positions in lifts does not appear correct. All staff should know the proper harness size. All staff	F 689		

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F 689	Continued From page 47 should be aware of safe patient handling techniques. During interview on 3/25/24 at 8:48 a.m., EZ-Way manufacturer representative MR-(B) identified it was important to have the right size harness when using an EZ stand lift and referred to the color sizing chart for guidance. MR-B explained if someone was using the wrong size sling, for example extra-large, but assessed for large they could go out of it if they let go. The purpose of the straps on the harness (chest strap) and lower leg was to stabilize and provide support and up to the facility on recommendations for residents. Facilities should ensure residents were able to bare weight and hang on with one hand, however if a resident is falling to one side or really hanging in the harness, they should not be using an EZ stand. It was not the expectation for a resident to be sinking in the position of the shoulders coming up above the ears and residents should not be in a hanging position. EZ lift harness loops should never be double looped. The longest loop is for a reclining chair and the closest one is to support to come to a standing position. The risk of double looping could cause one of the loops to sit on each other causing the loop to slide off from the lift causing a risk of falling. Facility's safe patient handling and resident transferring policy were requested and not received. ELECTRONIC PERSONAL ALARM SYSTEM R9's quarterly Minimum Data Set (MDS) dated ,3/5/24 identified R9 had severe cognitive impairment. Behavior of wandering was not	F 689		

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F 689	Continued From page 48 exhibited. Wandering impact was not assessed. Facility reported incident dated 11/7/23, identified on 11/6/23 R9 was last seen in the dining room at around 4:50 p.m. at around 5:10 p.m. the nurse heard the wonder guard alarm going off/sounding and responded to the alarm. The nurse turned off the alarm and started looking for R9. R9 was located in the neighboring unit which he had previously resided on. R9 had covered himself up with a blanket in another patient's room. The resident was wearing his wander guard which sounded the alarm. Nursing staff did not react to the alarm quickly. R9's care plan updated 11/7/23 identified R9 to have exit seeking, wondering and elopement due to vascular dementia. Staff are to monitor alert in room. Other: wander guard which was initiated on 4/18/23. Care plan updated on 11/7/23 to have frequent checks every 15 minutes to ensure resident is within view. Place monitoring device that sounds when attempts to leave unit/building. Wander Alert: left wrist device # model [tag barcode B 2819 8638] R9's order dated 3/28/24 directed staff to check wander guard for blinking light. Report to nurse manager if not blinking for a replacement device every day and every Thursday. R9's order dated 3/21/24 identified R9 had the wonder guard on left wrist and staff were to check for placement every shift to ensure red light is blinking. R9's interdisciplinary team meeting (IDT) identified R9 Eloped on 11/6/23 intervention was wander guard on and monitoring. The root cause	F 689		

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F 689	Continued From page 49 of the incident was R9 was known to wander. R9 is mobile and able to walk off a secured unit while nursing was in other residents rooms and unable to hear wander guard arm, alarming. Summery of internal investigation identified R9 had eloped from a secured unit (wander guard protected) by eloping after dinner. The wander guard doors were not locking when alarmed. Double doors from TCU2 are now wander guard protected with alarm and locking activated. ELDR Invoice with executed time of 11/7/23 and ticket number 15666 identified a test and troubleshoot for TCU2 door and had to rewire the door correctly. Found there was not enough power to run all the hardware for the door. It's only 12 volts and it drops to 8.6 when locks are engaged so another power supply needed to be installed that is 15 volts and should be fine. Executed time of 11/8/23 and ticket number of 1566 indicated service of being back on site to test power supply and it had enough volts, but not enough amps will find a 4 or 5 amp power supply to make it work correctly R9's progress note dated 3/17/24 identified resident was wandering in the hallways when writer arrived for shift at 6:30 a.m. without walker. Given reminders and assisted back to room. R14s face sheet undated identified diagnoses to include Alzheimer's disease with late onset and Dementia R14's admission Minimum Data Set (MDS) dated 1/22/24, identified R14 to have severe cognitive impairment. R14 wandering assessment identified behavior of this time occurred 1 to 3 days. The wandering did not place the resident at	F 689		

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F 689	Continued From page 50	F 689		

significant risk of getting to a potentially dangerous place (E.g. Stairs, outside of the facility). The wandering did not significantly intrude on the privacy of activities of others.

R14's care plan dated 2/19/24 identified exit seeking/wandering/elopement and required a secured unit placement due to wandering. Wander alert: device located on right wrist B24193849.

R14's order dated 3/27/24 directs staff to check placement of wander guard tag every shift on resident right wrist. Every shift for elopement prevention.

R14's treatment administration records dated 2/19/24 directs staff to check wander guard for blinking light. Report to nurse manager if not blinking for a replacement device.

R12's face sheet identified diagnoses to include dementia and unspecified symptoms and signs involving cognitive functions and awareness.

R12's care plan dated 1/16/24 identified exit seeking/wandering/elopement and R12 had a wander alert on left ankle device # model B37203713.

R12's order dated 2/22/24 direct staff to ensure wander guard is blinking on device. Update nursing management if light is not blinking for a replacement device. Every shift every Thursday.

R12's order dated 1/15/24 direct staff that R12 has a wander guard on right ankle, check for placement every shift and ensure red light is blinking.

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F 689	Continued From page 51 R12's progress note dated 3/21/24 identified R13 was alert confused/forgetful. He is orientated to self, person. Has been wandering around unit with and without his walker standing in resident's doorways and when trying to redirect him he becomes angry and agitated saying nonsensical things back. He likes to be out of the room most of the day. . During interview on 3/21/2024 at 3:00 p.m., director of maintenance (DM)-A reported to be responsible for testing the WanderGuard system monthly. DM-A reported his responsibility was the zone coverage testing and operation and nurses were responsible for the set-up, application, and monitoring of the devices. DM-A reported the system had been operating with no issues for the last couple of years. DM-A demonstrated this process by taking a wander guard (LC1200System Tag) and a Secure tag activator/deactivator (S-TAD) and activating on and proceeded to check the battery life. If the low battery LED symbol appeared on the S-TAD it indicated the battery was low and needed to be replaced. You could not detect percentage of battery life with the S-TAD reader and the blinking light indicator is for zone coverage and activation, however not for battery life. DM-A reported never having had a reading of low battery when testing the system, but if they had, it would need to get discarded as they were not reusable. The wander guard tags were located in an unlabeled bin. During demonstration of the S-TAD operation DM-A picked a wander guard tag and identified it was low and reported "its hard to believe but this is the first time I have ever seen a low one". The low battery tag was located in the same bin as other usable wander guard tags. DM-A located a	F 689		

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F 689	Continued From page 52 tag that was not reading "low battery", took the activated wander guard and walked into the field of zone coverage that triggered the activation system. The wander guard had a blinking light on it identifying it was on and activated. You could confirm the field was detected by the blinking light turning solid. Once the device was detected the door would lock and unable to pass through. The systems auditory alert was at the nurses station and was not audible near the door itself or throughout the whole unit. DM-A demonstrated this with a wander guard not on a resident on reflections memory care unit. Then demonstrated it with a current resident on the unit, R12. R12 came up from the side of the door and not directly at it. R12 was able to get within arm's reach of pushing the door handle and opening it. The door did not lock appropriately and did not respond to R12's wander guard. R12's battery life on the guard was not low. During interview and observation on 3/21/24 at 5:15 p.m., DM-A tested R9's [tag barcode B-3220-3832] (who is now residing on reflections memory care unit) and R14's [tag barcode B-0820 3434] battery life of the wander guard both read as "low battery life" on the S-TAD detector. When attempting to pass through the zone coverage the system did not alarm and was able to walk through the door without the system triggering. DM-A reported a person wearing a wander guard alert band should not be able to walk through the doors. The blinking light indicator of turning solid was inconsistent with the field of zone coverage. However, the blinking light indicator identified it was active and functioning. During interview on 3/21/24 at 3:21 a.m., registered nurse RN-(A) reported the wander	F 689		

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F 689	Continued From page 53 guard system was only heard near the nurses station and was not audible down the hall or if you were in a room. RN-A reported the nursing staff is responsible for checking if they walk by visualizing the blinking light on the wander guard and the blinking light meant it was working. Wander guards are checked every day shift, on Thursday's. R14's wander guard was checked on this day and was working by visualizing the blinking light. Nurses get the information about checking the wander guard systems in the orders and on the treatment administration record (TAR).RN-A reported nurse manager NM-(B) was responsible for checking the batteries, the nurses are just to look at the blinking light of the wander guard. During interview on 3/21/24 at 3:09 p.m., nurse manager NM-B reported if the wander guard gets close to the door it activates and the door locks . NM-A reported R9 required frequent checks and when staff are walking down the hall they try to check on him. Frequent means every one hour. R9 tends to wander looking for his wife, NM-B reported knowing wander guards are working by the blinking light on the wander guard and checks the wander guards by bringing residents to the door to see if it activates the system. NM-B reported the black thing [S-TAD] is to turn them on/activate them for new residents. During interview on 3/22/24 at 1:16 p.m., NM-B reported maintenance came to check and fix the doors yesterday and all of the batteries for the wonder guards were checked with the black thing [S-TAD]. NM-B reported training happened yesterday and learned how to use the S-TAD to check to see if there was a low battery. If a low battery is identified, it needs to be immediately	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANOKA REHABILITATION AND LIVING CENTER	3000 4TH AVENUE ANOKA, MN 55303

(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	F 689		

removed and brought to management. If it was working staff are to clean it and put it back in the medication room. NM-B was unaware about the life or how long the battery could be used for.

During interview on 3/26/24 at 10:47 a.m., director of nursing (DON) reported R9 eloped due to a problem with the doors which was resolved. Staff were educated and the door company was contacted to correct the concern. DON was unsure what happened with the doors or if there had been any further concerns. DON did not know if R9's wander guard tag battery life had been checked. DON reported if a resident was wearing a wander guard tag with low battery life they would be at risk for a successful elopement. DON thought staff were doing a check and monitor of the battery life and was under the assumption that is how floor staff were doing the weekly checks. DON was unaware of what floor staff were doing with the storage of used tags. DON did not know there was no tracking or trending of the wonder guard system for when the battery was low. Reviewed like residents who had gotten through the wander guard during this timeframe and DON reported the potential of someone opening the door from the opposite side could also be a potential to residents being able to get through the door. DON reported the reason R12's wonder guard did not activate was due to the field needed to be set higher so it triggered more area which was implemented on 3/21/24 at 8:00 p.m.

ELDR Invoice with executed time of 3/21/24 and ticket number 19921 identified DM-A called in an after hours support to call to test and secure the reflection double door. Report was the wander range was to narrow. After testing with the staff

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F 689	Continued From page 55 on duty the range was expanded to meet their needs. During interview on 3/25/24 at 12:03 p.m., manufactures representative MR-(C) reported to represent the company which installed the wander guard system, however the facility uses another third party to complete the maintenance by the name of ELDR. MR-C was aware a representative was at the facility on Friday 3/22/24 to change the (reset/escorting) bypass time from 30 seconds to 15 seconds, however, was not successful due to having a different companies keypad and the keypad was not compatible with the modifications. MR-C reported it was okay to be used in the way they were using it. Additionally wanted to expand the field which was completed successfully. MR-C reported wander guard tag batteries do not expire due to the ability of being able to turn them off and on. If a tag registers low battery then they need to be taken out of use. The risk of using a low battery is that the system would not be able to recognize it and you would have an successful elopement. Manufactures recommendation were for the batteries are checked weekly and testing the field monthly or now the manual says bimonthly. With the system in use there was no way to know what percentage a battery life was at or if it was fully depleted and only able to see a "low battery life" indicator which means it should be taken out of clinical use. Facility policy titled Wandering and Elopement dated 11/24/22 included "Maintenance will monitor all wander guard door alarm system doors on scheduled basis to ensure their functioning and maintain a written documentation. See Elopement Alarm Policy in nursing policies."	F 689		

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F 689	Continued From page 56 Elopement Alarm Policy referenced was requested but not received.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 12, 2024

Administrator
Anoka Rehabilitation And Living Center
3000 4th Avenue
Anoka, MN 55303

Re: State Nursing Home Licensing Orders
Event ID: KU4P11

Dear Administrator:

The above facility was surveyed on March 21, 2024 through March 26, 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.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	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 3/21/24, 3/22/24, 3/25/24 and 3/26/24, 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	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed H52052093C (MN00101744) H52052286C (MN00094480) H52052284C (MN00096246) H52052285C (MN00097170) H52052287C (MN00097294 & MN00098098) H52052329C (MN00094106) H52052333C (MN00098067) H52052331C (MN00098368) H52052332C (MN00101670) with licensing orders issued at (0565, 0830, 0905, 1665 and 1805). 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	2 000		

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2 000	Continued From page 2 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "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 observation, interview, and record review the facility failed to develop and implement the toileting care plan for 1 of 2 residents (R13) reviewed for toileting. Findings include: R13's significant change Minimum Data Set	2 565	Corrected	4/25/24

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2 565	Continued From page 3 (MDS) dated 1/23/24, indicated R13 was admitted to the facility on 9/23/23 with diagnoses including aphasia following intracranial hemorrhage (difficulty understanding or expressing speech following a brain bleed), muscle weakness, non-Alzheimer's dementia, depression, and arthritis. R13 required maximal assistance with mobility in bed and was dependent on staff for sitting up, lying down, transfers, and toileting hygiene. R13 was always incontinent of both bowel and bladder. R13's MDS dated 10/12/23, included the last Brief Interview for Mental Status (BIMS) completed, with a score of 3 indicating severe cognitive impairment. R13's Bowel and Bladder Data Collection assessment completed by nurse manager (NM)-B dated 1/20/24, identified R13 was always incontinent of urine, incontinence did not interfere with activities or recreation during the day, R13 slept through the night without interruption and was not being interrupted by a check and change schedule. R13 had no short or long term memory loss, could not identify the need or urge to void/defecate, was sometimes able to use the call light, was not able to ask to use the toilet, did not wake at night to void, did not have incontinent episodes associated with specific actions, and had suspected functional incontinence. The interventions for urinary incontinence were to establish a bladder routine and provide perineal care with pad changes. R13 had not had a trial of a toileting program and was not currently using a toileting program or trial. Diagnoses affecting elimination patterns included obesity, depression, and diabetes. Mobility/environmental limitations which could affect elimination included requiring assistance to transfer and requiring a mechanical lift. R13 was totally dependent for toilet use and	2 565		

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2 565	Continued From page 4 required two plus persons for physical assistance. Have new interventions or environmental modifications been added since last review was marked no. The amount of urinary incontinence episodes, number of times the resident wakes at night to void naturally, number of times resident is wakened at night to void by staff, if urinary incontinence is a direct result of a specified illness/injury, when the incontinence started, if resident had problems with leaking urine sections, and if resident showed patterns of urinary incontinence sections of the Bowel and Bladder Data Collection assessment dated 1/20/24 were not completed. R13's care plan noted a focus on activities of daily living (ADL's) because R13 had preferences and other items of need listed in her interventions. Interventions included frequent checks for bed and wheelchair repositioning and comfort initiated 11/10/23, assist of 2 staff for mobility in bed initiated 7/5/21, and assist of one staff for using the toilet with an EZ-Stand dated 7/6/21. R13's care plan included a focus on incontinence/altered elimination with goal of cooperating in establishing a routine for urine elimination. Interventions included R13 is always incontinent of bladder initiated 10/4/21, always incontinent of bowel initiated 7/6/21, assist to and from the toilet initiated 10/17/23, and establish a bladder routine initiated 10/17/23. R13's care plan included a restorative bladder program focus initiated 11/16/23, noting R13 had incontinent episodes related to decreased mobility. Interventions included directing staff to encourage and offer toileting/bedpan upon rising (around 9:00 a.m.), after lunch/before afternoon	2 565		

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2 565	Continued From page 5 activities (around 1:30 p.m.), after dinner while getting ready for bed (around 6:30 p.m.) and assist into green overnight pad (incontient briefs), and check resident at midnight and 5:00 a.m. and offer bedpan and change pad initiated 1/30/24 by assistant director of nursing (ADON). R13's care plan included a restorative bowel program focus initiated 11/16/23, noting R13 had increased bowel incontinence episodes related to decreased mobility. Interventions included directing staff to encourage and offer toileting/bedpan upon rising (around 9:00 a.m.), after lunch/before afternoon activities (around 1:30 p.m.), after dinner while getting ready for bed (around 6:30 p.m.) and assist into green overnight pad, and check resident at midnight and 5:00 a.m. and offer bedpan and change pad initiated 1/26/24 by ADON. R13's provider orders included an order dated 3/3/24, directing staff to encourage and offer toileting/bedpan upon rising (around 9:00 a.m.), after lunch/before afternoon activities (around 1:30 p.m.), after dinner while getting ready for bed (around 6:30 p.m.) and assist into green overnight pad, and check resident at midnight and 5:00 a.m. and offer bedpan and change pad to be completed five times daily. R13's nursing assistant care cards direct staff "please must be changed at 7:00 p.m, 12:30 a.m. 5:00 a.m. and 1:30 p.m. daily." The nursing assistant (NA) task charting section of R13's electronic health record (EHR) included toileting. It noted R13 needed to be changed around 9:00 a.m., 1:30 p.m., 7:00 p.m., 12:00 a.m., 5:00 a.m., and as needed, and directed "you need to chart this no matter what. Also notify	2 565		

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2 565	Continued From page 6 the nurse." Review of charting for this task from 3/13/24 through 3/26/24 included the following times: 3/13/24 at 5:00 a.m. 3/15/24 at 2:28 a.m., 2:29 a.m., and 11:29 p.m. 3/16/24 at 5:00 a.m. and 10:54 a.m. 3/17/24 at 12:00 a.m. and 5:00 a.m. 3/19/24 at 12:18 a.m. and 5:00 a.m. 3/20/24 at 1:43 p.m., 1:44 p.m., and 11:23 p.m. 3/21/24 at 5:00 a.m. and 11:57 p.m. 3/22/24 at 5:00 a.m., 9:00 a.m., and 1:30 p.m. 3/23/24 at 6:30 p.m. 3/25/24 at 11:47 p.m. 3/26/24 at 5:00 a.m. No other completion times for this task were documented during this time frame. During continuous observation and interview on 3/26/24 at 5:27 a.m., NA-E was observed on the unit, however never entered R13's room. At 7:52 a.m. NA-A and NA-B entered R13's room to complete morning cares. R13 was brought to the toilet with the use of an ez stand mechanical lift and NA-B doffed a white brief with gray sizing lines. NA-A and NA-B reported R13 was last toileted at 5:00 a.m. NA-B reapplied a clean white breif with gray sizing lines. NA-A and NA-B reported R13 only uses white breifs with gray sizing lines. During subsequent observation at 1:40 p.m. on 3/26/24 NA-A and NA-B were observed toileting R13. NA-B reported the last time she was changed was during morning cares and staff are to be changing every two hours and as needed. NA-A reported a toileting time may have been missed due to being very very busy. NA-B reported the brief which was removed was fully saturated and R13 needed to be changed.	2 565		

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2 565	Continued From page 7 Email communication dated 03/20/24 at 7:01 a.m., was from family member (FM)-B to DON, ADON, Administrator, nurse manager (NM)-(A) and NM-B and expressed concerns within the last week and noted the following had occurred: "- Monday [3/18/24] got up at 7:55 am not to receive a diaper check or change until 3:45 pm - 8 hours. - Left in bed for 3 hours calling to get out with noone checking her from Tuesday [3/19/24] 1:45 pm - 5:05 pm - never checked on by any staff. - Placed to bed Tuesday evening [3/19/24] at 7:15 am, no diaper check or reposition until 4:55 am this morning - almost 12 hours. I willl be coming in after work this morning to check on her and expect to have answers as to why her care plan has not been followed and to decide what action needs to be taken. I was told Monday that the care plan was going to be executed which didn't even last one day. We are truly concerned with the level of care being provided in River Bend as a whole with not only mom but other residents as well. We are hoping this sudden change in care for our mom was not reflective of claim filed justifiably with state as we were not the only resident family who filed claims. " During review of FM-B video footage dated 3/20/24, FM-B was in R13's room speaking with the ADON about R13's care.Video footage shows digital clock time of 11:08 a.m. due to outside lighting. FM-B reported video footage showed R13 was put to bed at 7:15 p.m. the night before and staff did not enter the room again until 5:00 a.m. that morning. FM-B reported R13 was never repositioned or checked which usually happened at 12:00 a.m. or 1:00 a.m. FM-B stated this was "totally off" from the care plan. FM-B stated she	2 565		

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2 565	Continued From page 8 did not know why staff suddenly failed to follow R13's care plan for toileting and repositioning. FM-B stated this was discussed in a meeting and things had been "solid" since the care plan meeting. FM-B asked the ADON, "All of a sudden are we changing it [care plan] without me knowing?" The ADON replied no. FM-B stated she wanted R13 to be repositioned at night in accordance with the care plan. On 3/26/24 at 7:41 a.m., Tena brand incontinence products, including briefs, were observed in the clean utility room on the Riverbend long term care unit where R13 resided. Briefs included Tena Proskin Stretch Ultra briefs in size medium (purple colored) and large/extra large (tan colored) and Tena Proskin Stretch Super briefs in size medium (green colored) and size large/extra large (green colored). NM-B stated the facility used Tena brand incontinent products, including briefs. The briefs came in different sizes and styles. NM-B identified the green briefs were only for nighttime; the Ultra briefs were for days and the Super/green briefs were for night because they absorbed more liquid. In an interview on 3/26/24 at 1:04 p.m., NA-B stated R13 only used the gray colored briefs that were in her room. When asked what type of brief R13's care plan directed staff to use, NA-B reported "I don't know, go ask [NA-A]." During an observation on 3/26/24 at 1:08 p.m., a pack of Tena Proskin Stretch Ultra briefs in size extra extra large (2XL) that were gray colored were noted on the floor next to the cabinet in the private bathroom in R13's room. In an interview on 3/26/24 at 1:12 p.m., NA-A confirmed the pack of briefs in R13's room were	2 565		

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2 565	Continued From page 9 the gray Ultra style briefs. NA-A stated they were for both overnights and days, they were R13's size of 2XL and were the only ones that really fit her and the only ones she used. NA-A noted there was a pack of old ones in the bathroom in size XL, but they didn't fit R13 and staff did not use them. NA-A stated the green overnight pad was different from the one R13 was using. NA-A stated that if a resident's care plan says green pads, it means they needed to specifically wear that type of pad and there were certain residents who had the green briefs for nighttime use. NA-A reported that staff needed the nighttime briefs because residents weren't checked on as often at night and they held more urine and soaked in more moisture compared to the daytime briefs. NA-A confirmed that R13 was wearing a gray brief and not a green brief when she was changed that morning. In an interview on 3/26/24 at 1:45 p.m., the ADON and NM-B identified the Bowel and Bladder Data Collection assessment completed by NM--B dated 1/20/24, identified that it included check and change scheduled every two hours or as needed for R13, and reported that facility staff used the care plan as a guide for toileting and the care plan should be followed. NM-B confirmed R13's care plan said she should be using a green overnight brief. When informed of the observations on 3/26/24 of 7:52 a.m. and 1:40 p.m. toileting times, the ADON reported R13 should have been changed before 1:40 p.m. around lunchtime and that toileting time was missed. The ADON stated if a resident missed toileting times it could lead to skin breakdown. The ADON reported according to R13's care plan, staff should be using the green briefs and their purpose was to allow residents to sleep longer because they held more urine. The ADON stated	2 565		

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2 565	Continued From page 10 if R13 was not wearing green briefs the moisture-wicking component would be the concern. NM-B stated the green briefs did not come in a 2XL size, they came in a 3XL size but those were too large for R13. NM-B reported the facility had never had the green briefs in size 2XL and the ADON reported he was aware they had green briefs in size 3XL but had not realized the facility did not have size 2XL. The ADON and NM-B stated it was staff's responsibility to let management know if they did not have a product available for a resident. The ADON stated it was not his understanding that R13 wearing standard briefs at night would change anything. The ADON stated R13 was to get up at 5:00 a.m., 9:00 a.m., 12:00 a.m., 2:00 p.m. and 7:00 p.m. and was okay going five hours in a standard brief. Facility policy titled Comprehensive Care Plan dated 10/2022, included: "Policy: It is the policy of Volunteers of America to provide a temporary care plan within 48 hours of admission (Admission Individual Care Plan) and a complete person centered and comprehensive care plan by the resident's 21st day of admission. The care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible consistent with resident rights. Procedure: 5.) This comprehensive care plan will have problem/strength statements, measureable goal statements, treatment preferences and interventions. The care plan will be written in a culturally competent manner recognizing the patient's diverse values, beliefs, and behaviors, including tailoring delivery to meet patient's social, cultural, and linguistic needs. 9.) Interventions should be written to help meet the resident's goal. The intervention should be individualized to the resident and Kardexed to update the resident's	2 565		

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2 565	Continued From page 11 individual care planned needs." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on implementation of comprehensive care plans for all residents. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all staff members are aware of the use of comprehensive care plans and are adhering to residents' individual comprehensive care plans 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	2 830		4/25/24

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2 830	Continued From page 12 by: Based on observation, interview, and document review the facility failed to use mechanical standing lifts in accordance with manufacturer recommendations for 2 of 3 residents (R1, R13) reviewed for accidents. Additionally, failed to ensure the wander-guard system was operational to prevent elopement for 3 of 4 residents (R9, R14, R12) reviewed for elopement. Findings include: MECHANICAL LIFTS and COMMODE R1's face sheet identified R1 had diagnoses including multiple sclerosis (MS), vascular dementia, and hemiplegia and hemiparesis (one-sided paralysis) following cerebral infarction (stoke) affecting right dominate side. R1's quarterly Minimum Data Set (MDS) dated 2/16/24, identified R1 was cognitively intact and required substantial/maximal assist to roll left and right and move from sitting to lying or lying to sitting. R1's care plan dated 6/2/23, identified R1 had activity of daily living (ADL) self-care performance deficits due to MS with right sided weakness requiring extensive assist for most cares.R1 required an EZ-Stand with two staff assist for all other [outside of getting in and out of bed] transfers. Staff were to double loop per patient preference, and sling size large- burgundy. Please be aware of placement of my hand when buckling the harness to avoid pinching skin. R1's nursing assistant (NA) care guide dated 3/8/24 identified R1 required the use of an EZ-stand lift with assist of two staff and sling	2 830	Corrected	

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2 830	Continued From page 13 [harness] size large. During interview on 3/21/24 at 9:30 a.m., family member FM-(A) expressed concerns regarding the way staff were transferring R1 with the use of the mechanical lift as it did not appear staff were using it correctly. FM-A had observed R1 hanging in the lift and was fearful R1 would slide through the harness. Additionally, FM-A reported concerns with R1 attempting to reach things such as her call light and leaning while seated on commode. During interview on 3/22/24 at 10:31 a.m., NA-D reported staff could not leave R1 alone on the commode due to safety. R1 didn't typically keep her body position upright and always leaned to her right. If R1 was in the lift and started to get tired she would let you know. At that point, the transfer needed to be stopped and R1 needed to be sat back down. R1 could fall if she got too tired. NA-D reported R1 used a large red [burgundy] harness. R1 required the lower leg strap and to make sure the harness was tight. R1 required 1 black loop connected from the harness to the EZ stand to support R1's upright position staff are to not use more then one loop at a time. If there was ever a concern with equipment, facility staff needed to remove it from the unit immediately and notify maintenance. R1's weight dated 3/21/24, identified R1 to be 212.8 pounds (lbs). During observation of video camera footage dated 3/20/24, R1 was noted to be seated on a bariatric drop arm commode unsupervised while attached to a mechanical EZ-stand lift. R1's upper body was leaning and up against the right side with her right arm dangling supported by arm	2 830		

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2 830	Continued From page 14 rest of the commode. R1 was attempting to reach the call light located on her right pant leg requiring R1 to reach toward her hemiparetic side down towards her knee and appeared to be struggling to reach the call light. R1's lower leg strap was not applied when staff entered room and progressed with transfer off the commode. During observation on 3/21/24 at 1:13 p.m., R1 was transferred from wheelchair to commode with use of mechanical EZ stand lift by NA-B and NA-C. The lift's calf/leg safety strap had significant slackl NA's were altered by the surveyor, NA's then cinched the strap so it was snug. NA's applied a green harness around R1's back and connected the harness by double looping the hooks on the lift. Once R1 came to a standing position the upper belt was not tightened also causing significant slack in the support harness positioning. Once R1 was seated, R1 was leaning to right side on the commode while attached to the lift. NA-B and NA-C directed R1 to call for help when done toileting and left R1's room leaving her unattended on the commode attached to the lift. Once NA's reentered the room, NA's changed the double to a single black loop. When the NA's started raising R1 off the commode, R1's hemiparetic arm was pressed between the side of the commode and her body, NA's did not stop raising R1 until the surveyor alerted the NA's of R1's position. After R1 was correctly positioned and lifted off the commode the commode became off balance and started tipping. Once R1 was in a standing position in the lift R1 was only hanging onto the lift with her left hand, the right arm hung down at her side. NA-B walked away from R1 to get gloves while NA-C gathered incontinent supplies. R1 began to "sink" or slouch from an upright position so that R1's bottom was parallel with the floor and appeared	2 830		

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2 830	Continued From page 15 to be dangling in the harness. R1 demonstrated labored breathing and stated "I am getting really tired". R1 had labored breathing and inability to stand upright. Even though NA's were alerted to R1's fatigue and positioning in the lift, NA's continued to provide incontinent cares and put on R1's brief. By the time cares were completed, R1's right shoulder was up and over her right ear and the back of the harness was up to the level of her neck instead of the middle of her back causing R1's neck to become in a forward/crouched position due to the harness pressure on her neck. During interview and observation on 3/21/24 at 1:30 p.m., NA-B and NA-C stated commode was not balanced and identified the right rear commode leg was not in the metal support bracket, the right front was on the second bracket with the left front and left back were on the third bracket. Due to height setting discrepancy the commode had approximate 2.5" height difference causing the commode to be unstable and tip when weight was applied to it. NA-B and NA-C reported commodes were not supposed to tip or move like that. Even after the NA's identified the commode was unstable, NA-B cleaned the commode and placed it back into the general storage area for subsequent use. During interview on 3/21/24 at 1:27 p.m., NA-B reported she was in charge of the set up of the transfer and NA-C was the driver of the lift. NA-B explained the waist strap of the harness should be tightened as a resident comes to a standing position but forgot to do so during the transfer. NA-B also reported the leg straps need to be tightened for support and felt R1's legs were good and supported once it was tightened. NA-B stated R1 was to use the green XL harness and pointed	2 830		

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2 830	Continued From page 16 to the coloring on the harness which was also green and what they used during the transfer. R1 was to only have 1 of loop of the harness used to connect to the lift on each side, but some people used two loops depending on their weight and identified it was corrected during the transfer of going from the commode to the recliner. NA-B was unable to identify R1's fatigue level and explained "it was normal" for R1 "to hang in the lift" because R1's right arm did not work. NA-B stated R1 was okay to leave on the commode while hooked up to the EZ stand and R1 would use the call light when she was done. The EZ-way Harness manufacturer's color coding system identified a green harness as an extra large for people between 280 and 450 lbs. The large harness is burgundy and for people between 190 and 320 lbs. Per manufacturer guidelines, a large burgundy size harness was appropriate for R1. During interview on 3/21/24 at 2:15 p.m., NA-C reported R1 required assist of two staff for the mechanical EZ stand and R1 used the green size harness and thought that was what should be on the care plan. If nursing assistants had questions about the care plan, they would log in to the computer and see it. NA-C was not sure if the facility had care cards/guides. NA-C reported both loops were connected to the lift due to R1's preference. NA-C reported most residents require one harness loop, but was not sure about the rules for only needing one loop. NA-C reported seeing R1 starting to sink and would usually put R1 down in a seated position to provide a rest, however did not due to NA-B needing to complete peri care tasks. NA-C identified if they would have kept going R1 would have fallen from the lift. NA-C reported R1's right arm always hung and	2 830		

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2 830	Continued From page 17 did not notice R1's arm was caught upon coming up to a standing position until intervention was provided. NA-C reported both the upper straps and lower straps should have been tighter. During interview on 3/21/24 at 3:41 p.m., director of maintenance DM-(A) reported no maintenance requests had been made regarding a commode. During review of the commode, DM-A identified the commode leg setting was not engaged in the metal bracket and the legs were not set evenly. DM-A reported the commode should not be in general use in its current condition. The appropriate process was for staff to immediately remove it from the floor due to the risk of someone using equipment that needs attention. DM-A stated if a resident used the commode in the situation observed, the resident would be at a high risk of falling and "cracking their head". During interview at 3/21/24 at 3:50 p.m., nurse manager NM-(A) reported she had been notified about the commode and was planning on going to check on it. NM-A had not because of shift change and was telling staff about the commode, however had not checked on it yet or pulled it from general storage area for subsequent use. During interview on 3/22/24 at 10:39 a.m., licensed practical nurse LPN-(A) reported staff should never leave R1 alone while attached to the lift due to the risk for R1 falling or tipping which could lead to injury or death. LPN-A reported staff should follow the resident safety and supervision guidelines and gestured to the resident safety and supervision guidelines located on the wall. LPN-A reported deserving R1 transfer and expressed concerns of R1's positioning due to heavy leaning from her hemiparesis and inability to support body on the right side and R1 leans very far to the	2 830		

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2 830	Continued From page 18 right side and could fall. Staff were to use the harness that was directed by the care cards and care plans. If there was ever a concern with equipment it should be removed from the unit immediately and reported to maintenance. Employee notification instruction sheet titled Resident Safety and Supervision, undated located on nursing station wall. Related to Resident Position and Mechanical Lifts directs staff to never leave a resident in a potentially unsafe position. Always consider the residents cognition, condition, fall risk/fall history when determining when it's appropriate to leave the resident unattended. Residents must not be left unattended when attached to mechanical lifts such as EZ Stand or EZ Lift (Hoyer). Including when seated on the toilet. Remember to check the care plan and care guide for information on resident's risks for falls and fall interventions. During interview on 3/25/24 at 10:46 a.m. NOVA heavy duty drop-arm commode manufactures representative MR-(A) reported it was very important to use bariatric drop arm commodes properly and misuse could cause a safety concern or fall. The metal brackets need to be secured in place and checked prior to use to avoid the product being unlevel. Using the product on different leg adjustments could lead to injury or falls. The commode was not to be used while attached to any sort of mechanical lift unsupervised as a person should have their feet flat on the ground and knees at a right angle and a resident should be able to maintain an upright sitting position. The arms of bariatric drop arm commodes were not meant to support body weight and could give way if a resident applied excessive pressure to it.	2 830		

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2 830	Continued From page 19 Nova heavy duty drop-arm commode item #8583 manufacturer recommendations identified the legs must be adjusted to same height (number) so the commode sits level. Make sure legs and backrest are secure (push button locked completely into hole) before using. Check before each use. Use on a level surface. Equipment repair policy dated 5/18/23 identified inoperative or malfunctioning equipment shall be promptly reported, in writing, to the maintenance department via the repair required for or TELS (electronic maintenance system). Conditions which warrant immediate attention must be verbally communicated to the maintenance director or designee as soon as the condition is discovered, to ensure prompt resolution. R13's face sheet identified diagnoses including aphasia following intracranial hemorrhage (difficulty understanding or expressing speech following a brain bleed), morbid (severe) obesity, muscle weakness, and vascular dementia. R13's significant change Minimum Data Set (MDS) dated 1/23/24, R13 required maximal assistance with mobility in bed and was dependent on staff for sitting up, lying down, and transfers. R13 was dependent for toileting hygiene R13's MDS dated 10/12/23, included the last Brief Interview for Mental Status (BIMS) completed, with a score of 3 indicating severe cognitive impairment. R13's nursing assistant care guide identified R13 required the use of an EZ-stand transfer with	2 830		

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2 830	Continued From page 20 assist of one. Harness size was not identified. During a returned call on 3/27/24 10:16 a.m., FM-B reported she was R13's power of attorney due to R13 being unable to make her needs known. FM-B reported installing a camera system in R13's room to oversee R13's cares when FM-B could not be physically present. FM-B reported ongoing issues and provided video camera footage to the ADON, director of nursing, and administrator and wrote grievances to management including a grievance from 11/17/23 and ongoing lack of safety since with the use of mechanical lifts. FM-B reported emailing facility staff about a concern with a transfer which happened on 3/20/24 as it appeared the transfer was not completed properly and was causing R13 pain. FM-B expressed R13 appeared to be dangling and not hooked up appropriately and fearful R13 could have fallen from the lift. FM-B reported the concern to be ongoing as there had been situations FM-B observed staff not clasping straps or using mechanical lifts correctly. FM-B reported no facility staff connected with her regarding this email on 3/20/24 outside of the initial response. Grievance with a date of occurrence on 11/17/23 from FM-B regarding R13 identified FM-B called director of nursing (DON) on 11/20/23 with concerns about her mothers left hand having trauma related injury from a EZ-stand transfer [which happened on 11/17/23].FM-B was concerned that during an EZ stand transfer, her mothers hand placement was an issue and caused R13 discomfort in her left hand. An x-ray was ordered and negative for a fracture. Her left hand appears with mild swelling and is receiving ice. FM-A requested the nursing staff to be educated on R13's transfer status and how to	2 830		

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2 830	Continued From page 21 properly stand with the EZ stand. Summary of investigation completed by DON on 11/21/23. included reviewing nursing assistant assignment board and video camera with FM-B. Interviewed and educated nursing staff , nursing management and interdisciplinary team (IDT). Resident had been downgraded to the use of a Hoyer lift with assist of two staff. Email communication on 3/20/24 at 7:01 a.m., from FM-B to administrator, DON, assistant director of nursing (ADON) and NM-A and NM-B included "They were having trouble to get mom to bed and it was 10 p.m. so I told them to use the lift [fully body mechanical hoyer lift] I pulled up video and was disturbed to find she [R13] wasn't hooked up correctly the first time and was pulled her awkwardly causing her pain. They had to bring her back down and correctly fix the straps. Video is attached.".FM-B received a response on 3/20/24 at 8:49 a.m., from DON "Hi [FM-B], please let us know when you will be in today so we can talk. Thanks" Video image attached to the email 3/20/24 at 7:01 a.m., showed R13 seated in a wheelchair in her bedroom. Two female facility staff members enter room with a full body mechanical lift. Staff members applied the full body sling behind R13. Staff members did not apply the back side of the sling under R13's tail bone. R1's lower straps were crossed under R13's legs. Staff then applied the shoulder straps appropriately to the lift. Upon attaching the lower leg straps to the lift, the left leg strap is twisted and under R13's leg near knee and not under her thigh or hips. R13 was visualized screaming and crying "oww" "ouch" "oh my god" and grimacing as the lift continued to cause ongoing pressure in the rising position. Facility staff members told R13 "it's okay calm	2 830		

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2 830	Continued From page 22 yourself" as R13 continued to sink lower through the hole of the sling. As tension is applied to the lift to raise R13 up from the wheelchair R13 became in a V like position Facility staff then start lowering R13 back to the wheelchair and at 0:03:09 it was visualized that the left leg support is noted to be under R13's knee and twisted. R13's legs were in an uneven position. R13 continued to call out in pain as staff attempted to reposition the sling. Video footage ends prior to a complete and safe transfer. EZ-way regular sling operator instructions for a full body mechanical lift for transferring a patient from chair, wheelchair or toilet direct staff to do the following. To set the sling properly, you must do the following: on the patients right side, position your hand between the patients hip and the sling. With your fingers push down on the edge of the sling so it touches the base of the chair seet. Next, grasp the bottom edge of the sling leg with your left hand and pull with a tug towards you. Lift the patients left knee and with a tug, pull the leg of the sling under the hip and thigh. Staff are to repeat procedure on the right size. This procedure will ensure the sling is under the patient's tail bone and behind his/her back, with the patients weight evenly distributed on the sling. Note: make sure all seams of the sling are smooth underneath patient. During observation of video camera footage from 3/20/24 at 1:10 p.m.,R13 was using a sit to stand EZ-Stand Mechanical lift. R13's harness strap was not at her waist and was at breast level and not tight to R13's chest. When staff asked if R13 was okay she shook her head no, staff did not respond to R13's non verbal expression. Staff did not apply the lower leg strap to R1's lower extremities. The driver of the lift did not identify	2 830		

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2 830	Continued From page 23 the reason the lift was not moving was due to a call light cord on the ground. The driver of the machine attempted to push over the cord before the second helper intervened and corrected it. EZ way manufacturer instructions for the the EZ-Stand mechanical lift harness directed for the harness to be positioned around the upper body so the sides of the harness are between the patients torso and arm, resting two to three inches below the underarm. For the safety of the patient securely fasten the safety strap around the patients torso. Secure the buckle and pull the straps to tighten. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. Use of shin pad strap: if a caregiver deems it necessary to keep a patients shins or feet on the foot plate, secure the shin strap around the patients legs. During observation and interview on 3/26/24 at 8:12 a.m., NA-A and NA-B assisted R13 to a sitting position on the edge of the bed however R13 was not sitting straight and leaned to one side. NA-B applied the EZ stand harness and attached it to the lift, however because R1 was leaning and not centered on the edge of the bed, R13's feet were not touching the platform of the lift . Chest strap was applied and NA-B reported "okay we are going up". The calf strap was not applied until the surveyor questioned if it was supposed to be, NA-B indicated she forgot it and did not identify R13's feet were not on top of the platform. Again the surveyor questioned NA's if R13's positioning on the lift was appropriate. NA-B then corrected R13's position by moving her feet forward onto the platform of the lift NA-B and NA-A reported the lower strap should be applied prior to transferring and a resident's feet should be on the platform.	2 830		

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2 830	Continued From page 24 During interview on 3/21/24 at 1:27 p.m., NA-B reported when using EZ- Stand lifts when you apply the chest harness to a resident the strap should be tightened and if it came loose while standing it should be tightened again. Lower leg straps should be applied for residents and also be tightened. The foot plate on the EZ-stand should be where the resident's feet were before standing. During interview on 3/26/24 at 8:47 a.m., NA-A reported being the nursing assistant for R13 this day and reported the strap should have been added and R13's feet should have been on the platform prior to keep going with the transfer. During interview on 3/22/24 at 11:18 a.m., director of nursing (DON) reviewed video footage 3/11/2024 through 3/20/2024 of R1 in the EZ stand with nursing staff. DON reported concerns of R1 in a hanging position, the upper belt not being tightened upon standing and R1's level of assist needs to clarified and reassessed. In reviewing video footage from 3/20/24 DON reported R1 should not leaning over the side of the commode as R1 is at a high risk for falls in the observed position. With R1's arm dangling and being transferred improperly this could result in injury to R1. The expectation with improperly working equipment is that it is pulled from use immediately. DON reported identifying concerns regarding the EZ stand and residents should be able to an upright position and the straps should be applied for both the harness and the lower legs. Nursing assistants need to know how to identify when transfers are inappropriate and notify a nurse. Staff need to recognize safety concerns, stop and readjust when residents positions in lifts does not appear correct. All staff	2 830		

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2 830	Continued From page 25 should know the proper harness size. All staff should be aware of safe patient handling techniques. During interview on 3/25/24 at 8:48 a.m., EZ-Way manufacturer representative MR-(B) identified it was important to have the right size harness when using an EZ stand lift and referred to the color sizing chart for guidance. MR-B explained if someone was using the wrong size sling, for example extra-large, but assessed for large they could go out of it if they let go. The purpose of the straps on the harness (chest strap) and lower leg was to stabilize and provide support and up to the facility on recommendations for residents. Facilities should ensure residents were able to bare weight and hang on with one hand, however if a resident is falling to one side or really hanging in the harness, they should not be using an EZ stand. It was not the expectation for a resident to be sinking in the position of the shoulders coming up above the ears and residents should not be in a hanging position. EZ lift harness loops should never be double looped. The longest loop is for a reclining chair and the closest one is to support to come to a standing position. The risk of double looping could cause one of the loops to sit on each other causing the loop to slide off from the lift causing a risk of falling. Facility's safe patient handling and resident transferring policy were requested and not received. ELECTRONIC PERSONAL ALARM SYSTEM R9's quarterly Minimum Data Set (MDS) dated ,3/5/24 identified R9 had severe cognitive impairment. Behavior of wandering was not	2 830		

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2 830	Continued From page 26 exhibited. Wandering impact was not assessed. Facility reported incident dated 11/7/23, identified on 11/6/23 R9 was last seen in the dining room at around 4:50 p.m. at around 5:10 p.m. the nurse heard the wonder guard alarm going off/sounding and responded to the alarm. The nurse turned off the alarm and started looking for R9. R9 was located in the neighboring unit which he had previously resided on. R9 had covered himself up with a blanket in another patient's room. The resident was wearing his wander guard which sounded the alarm. Nursing staff did not react to the alarm quickly. R9's care plan updated 11/7/23 identified R9 to have exit seeking, wondering and elopement due to vascular dementia. Staff are to monitor alert in room. Other: wander guard which was initiated on 4/18/23. Care plan updated on 11/7/23 to have frequent checks every 15 minutes to ensure resident is within view. Place monitoring device that sounds when attempts to leave unit/building. Wander Alert: left wrist device # model [tag barcode B 2819 8638] R9's order dated 3/28/24 directed staff to check wander guard for blinking light. Report to nurse manager if not blinking for a replacement device every day and every Thursday. R9's order dated 3/21/24 identified R9 had the wonder guard on left wrist and staff were to check for placement every shift to ensure red light is blinking. R9's interdisciplinary team meeting (IDT) identified R9 Eloped on 11/6/23 intervention was wander guard on and monitoring. The root cause of the incident was R9 was known to wander. R9	2 830		

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2 830	Continued From page 27 is mobile and able to walk off a secured unit while nursing was in other residents rooms and unable to hear wander guard arm, alarming. Summery of internal investigation identified R9 had eloped from a secured unit (wander guard protected) by eloping after dinner. The wander guard doors were not locking when alarmed. Double doors from TCU2 are now wander guard protected with alarm and locking activated. ELDR Invoice with executed time of 11/7/23 and ticket number 15666 identified a test and troubleshoot for TCU2 door and had to rewire the door correctly. Found there was not enough power to run all the hardware for the door. It's only 12 volts and it drops to 8.6 when locks are engaged so another power supply needed to be installed that is 15 volts and should be fine. Executed time of 11/8/23 and ticket number of 1566 indicated service of being back on site to test power supply and it had enough volts, but not enough amps will find a 4 or 5 amp power supply to make it work correctly R9's progress note dated 3/17/24 identified resident was wandering in the hallways when writer arrived for shift at 6:30 a.m. without walker. Given reminders and assisted back to room. R14s face sheet undated identified diagnoses to include Alzheimer's disease with late onset and Dementia R14's admission Minimum Data Set (MDS) dated 1/22/24, identified R14 to have severe cognitive impairment. R14 wandering assessment identified behavior of this time occurred 1 to 3 days. The wandering did not place the resident at significant risk of getting to a potentially dangerous place (E.g. Stairs, outside of the	2 830		

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2 830	Continued From page 28 facility). The wandering did not significantly intrude on the privacy of activities of others. R14's care plan dated 2/19/24 identified exit seeking/wandering/elopement and required a secured unit placement due to wandering. Wander alert: device located on right wrist B24193849. R14's order dated 3/27/24 directs staff to check placement of wander guard tag every shift on resident right wrist. Every shift for elopement prevention. R14's treatment administration records dated 2/19/24 directs staff to check wander guard for blinking light. Report to nurse manager if not blinking for a replacement device. R12's face sheet identified diagnoses to include dementia and unspecified symptoms and signs involving cognitive functions and awareness. R12's care plan dated 1/16/24 identified exit seeking/wandering/elopement and R12 had a wander alert on left ankle device # model B37203713. R12's order dated 2/22/24 direct staff to ensure wander guard is blinking on device. Update nursing management if light is not blinking for a replacement device. Every shift every Thursday. R12's order dated 1/15/24 direct staff that R12 has a wander guard on right ankle, check for placement every shift and ensure red light is blinking. R12's progress note dated 3/21/24 identified R13 was alert confused/forgetful. He is orientated to	2 830		

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2 830	Continued From page 29 self, person. Has been wandering around unit with and without his walker standing in resident's doorways and when trying to redirect him he becomes angry and agitated saying nonsensical things back. He likes to be out of the room most of the day. . During interview on 3/21/2024 at 3:00 p.m., director of maintenance (DM)-A reported to be responsible for testing the WanderGuard system monthly. DM-A reported his responsibility was the zone coverage testing and operation and nurses were responsible for the set-up, application, and monitoring of the devices. DM-A reported the system had been operating with no issues for the last couple of years. DM-A demonstrated this process by taking a wander guard (LC1200System Tag) and a Secure tag activator/deactivator (S-TAD) and activating on and proceeded to check the battery life. If the low battery LED symbol appeared on the S-TAD it indicated the battery was low and needed to be replaced. You could not detect percentage of battery life with the S-TAD reader and the blinking light indicator is for zone coverage and activation, however not for battery life. DM-A reported never having had a reading of low battery when testing the system, but if they had, it would need to get discarded as they were not reusable. The wander guard tags were located in an unlabeled bin. During demonstration of the S-TAD operation DM-A picked a wander guard tag and identified it was low and reported "its hard to believe but this is the first time I have ever seen a low one". The low battery tag was located in the same bin as other usable wander guard tags. DM-A located a tag that was not reading "low battery", took the activated wander guard and walked into the field of zone coverage that triggered the activation system. The wander guard had a blinking light on	2 830		

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2 830	Continued From page 30 it identifying it was on and activated. You could confirm the field was detected by the blinking light turning solid. Once the device was detected the door would lock and unable to pass through. The systems auditory alert was at the nurses station and was not audible near the door itself or throughout the whole unit. DM-A demonstrated this with a wander guard not on a resident on reflections memory care unit. Then demonstrated it with a current resident on the unit, R12. R12 came up from the side of the door and not directly at it. R12 was able to get within arm's reach of pushing the door handle and opening it. The door did not lock appropriately and did not respond to R12's wander guard. R12's battery life on the guard was not low. During interview and observation on 3/21/24 at 5:15 p.m., DM-A tested R9's [tag barcode B-3220-3832] (who is now residing on reflections memory care unit) and R14's [tag barcode B-0820 3434] battery life of the wander guard both read as "low battery life" on the S-TAD detector. When attempting to pass through the zone coverage the system did not alarm and was able to walk through the door without the system triggering. DM-A reported a person wearing a wander guard alert band should not be able to walk through the doors. The blinking light indicator of turning solid was inconsistent with the field of zone coverage. However, the blinking light indicator identified it was active and functioning. During interview on 3/21/24 at 3:21 a.m., registered nurse RN-(A) reported the wander guard system was only heard near the nurses station and was not audible down the hall or if you were in a room. RN-A reported the nursing staff is responsible for checking if they walk by visualizing the blinking light on the wander guard	2 830		

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2 830	Continued From page 31 and the blinking light meant it was working. Wander guards are checked every day shift, on Thursday's. R14's wander guard was checked on this day and was working by visualizing the blinking light. Nurses get the information about checking the wander guard systems in the orders and on the treatment administration record (TAR).RN-A reported nurse manager NM-(B) was responsible for checking the batteries, the nurses are just to look at the blinking light of the wander guard. During interview on 3/21/24 at 3:09 p.m., nurse manager NM-B reported if the wander guard gets close to the door it activates and the door locks . NM-A reported R9 required frequent checks and when staff are walking down the hall they try to check on him. Frequent means every one hour. R9 tends to wander looking for his wife, NM-B reported knowing wander guards are working by the blinking light on the wander guard and checks the wander guards by bringing residents to the door to see if it activates the system. NM-B reported the black thing [S-TAD] is to turn them on/activate them for new residents. During interview on 3/22/24 at 1:16 p.m., NM-B reported maintenance came to check and fix the doors yesterday and all of the batteries for the wonder guards were checked with the black thing [S-TAD]. NM-B reported training happened yesterday and learned how to use the S-TAD to check to see if there was a low battery. If a low battery is identified, it needs to be immediately removed and brought to management. If it was working staff are to clean it and put it back in the medication room. NM-B was unaware about the life or how long the battery could be used for. During interview on 3/26/24 at 10:47 a.m.,	2 830		

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2 830	Continued From page 32 director of nursing (DON) reported R9 eloped due to a problem with the doors which was resolved. Staff were educated and the door company was contacted to correct the concern. DON was unsure what happened with the doors or if there had been any further concerns. DON did not know if R9's wander guard tag battery life had been checked. DON reported if a resident was wearing a wander guard tag with low battery life they would be at risk for a successful elopement. DON thought staff were doing a check and monitor of the battery life and was under the assumption that is how floor staff were doing the weekly checks. DON was unaware of what floor staff were doing with the storage of used tags. DON did not know there was no tracking or trending of the wonder guard system for when the battery was low. Reviewed like residents who had gotten through the wander guard during this timeframe and DON reported the potential of someone opening the door from the opposite side could also be a potential to residents being able to get through the door. DON reported the reason R12's wonder guard did not activate was due to the field needed to be set higher so it triggered more area which was implemented on 3/21/24 at 8:00 p.m. ELDR Invoice with executed time of 3/21/24 and ticket number 19921 identified DM-A called in an after hours support to call to test and secure the reflection double door. Report was the wander range was to narrow. After testing with the staff on duty the range was expanded to meet their needs. During interview on 3/25/24 at 12:03 p.m., manufactures representative MR-(C) reported to represent the company which installed the wander guard system, however the facility uses	2 830		

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2 830	Continued From page 33 another third party to complete the maintenance by the name of ELDR. MR-C was aware a representative was at the facility on Friday 3/22/24 to change the (reset/escorting) bypass time from 30 seconds to 15 seconds, however, was not successful due to having a different companies keypad and the keypad was not compatible with the modifications. MR-C reported it was okay to be used in the way they were using it. Additionally wanted to expand the field which was completed successfully. MR-C reported wander guard tag batteries do not expire due to the ability of being able to turn them off and on. If a tag registers low battery then they need to be taken out of use. The risk of using a low battery is that the system would not be able to recognize it and you would have an successful elopement. Manufactures recommendation were for the batteries are checked weekly and testing the field monthly or now the manual says bimonthly. With the system in use there was no way to know what percentage a battery life was at or if it was fully depleted and only able to see a "low battery life" indicator which means it should be taken out of clinical use. Facility policy titled Wandering and Elopement dated 11/24/22 included "Maintenance will monitor all wander guard door alarm system doors on scheduled basis to ensure their functioning and maintain a written documentation. See Elopement Alarm Policy in nursing policies." Elopement Alarm Policy referenced was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures related to falls,	2 830		

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2 830	Continued From page 34 accidents, and the use of mechanical lifts to assure proper assessment and interventions are implemented safely. The administrator or designee could educate all staff on these policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on resident safety, elopement, and the maintenance of relevant equipment . The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all staff members are aware of how to provide a safe environment for residents, prevent elopements, and properly maintain equipment utilized to prevent elopement and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.	2 905		4/25/24

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2 905	Continued From page 35 This MN Requirement is not met as evidenced by: SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on turning and repositioning. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all staff members are appropriately turning and repositioning residents and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 905	Corrected	
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a dignified living experience was maintained for 2 of 3 residents (R1 and R13) reviewed for dignity. Findings include: R1's face sheet identified R1 had diagnoses including multiple sclerosis (MS), vascular dementia, and hemiplegia and hemiparesis	21805	Corrected	4/25/24

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21805	Continued From page 36 (one-sided paralysis) following cerebral infarction (stoke) affecting right dominate side. R1's quarterly Minimum Data Set (MDS) dated 2/16/24, identified R1 was cognitively intact and required substantial/maximal assist to roll left and right and move from sitting to lying or lying to sitting. R1's care plan dated 9/26/19 identified R1 is at risk for ineffective coping related to diagnosis of MS, depression. R1 has noted behaviors of crying, tearfulness, sadness and is withdrawn at times. Likes to have her routine. She takes an antidepressant. R1 has expressed fear of covid and states she feels content in her room. The goal is for R1 to respond to redirection when tearful. Staff are encouraged and allow her to verbalize her feelings and participate in her cares. Update ND/NP on mood changes. Intervention dated 8/5/11 staff are to listen carefully to R1 and acknowledge feelings and concerns. R1's care sheet for facility staff identifies staff are to approach R1 for toileting by add to toileting routine is a check and change at 10 a.m. daily. Please approach resident and tell her "its time to change your brief". Do not ask her "do you want us to change you" or any variation of this. If her pants are wet, tell her " R1- your pants are wet and we need to change them." R1's grievance dated 05/10/23 for R1. Nurse referring to resident as "troublemaker" playfully, but resident does not appreciate it. Resident has been having to wait until 700 to get up, but wants to get back to getting up at 5:00. Nurse re-educated on resident rights. Resident and /or family to notify assistive director of nursing (ADON) or nurse manager of any further issues.	21805		

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21805	Continued From page 37 ADON is to check in with residents in AM until resolved. During review of the video camera footage recorded on 3/16/24. R1 was crying and had facial grimacing and pointing to her leg. Licensed practical nurse LPN-B was next to the bed while completing cares. R1was grimacing and crying. LPN-A then lifts up R1's right leg and R1 continued to cry harder. LPN-B said " wait wait wait stop crying and when your crying and talking we don't get what you're saying." LPN-B spoke loud and used strong toned body language using his hands for expression. During review of video camera footage recorded on 3/20/2024 R1 leaning over the side of the commode with the window shades open. A nursing assistant entered R1's room and leaves door open. R1's lower body was exposed to the hallway for 23 seconds until another aid came into the room and shut the door. R1's window shade was not closed and viewable to other residents in the courtyard. Staff compelted peri care with the shade opened. During interview on 3/26/2024 at 2:08 a.m., R1 reported its her preference to sit next to the bed and not by the window. R1 prefers to view the T.V. R1 stated she wants to a nice lady to staff so sometimes she will allow nursing staff put it wherever they want before providing care. However, R1 started it was frustrating when staff don't listen to her preferences including the proper positioning to her leg. During interview on 3/21/24 at 5:30 p.m. R1 reported facility staff to not "take her for who she is". R1 indicated needs and preferences are important to her and does not always feel listened	21805		

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21805	Continued From page 38 to. R1 reported to have a specific way of doing things and sometimes staff will talk over and not listen to her. During interview on 3/21/24 at 8:37 a.m., family member FM-(A) reported to be R1's power of attorney to help advocate for R1. FM-A reported viewing video camera footage which was disturbing to her. The video camera footage included people yelling at R1 and not listening to her needs. FM-A also reported R1 had been being changed in an open environment and the widows were open facing a courtyard and the bedroom door was open viewable to another resident's room while R1 was undressed from the lower half while going to the bathroom and these dignity and respect concerns are going against R1's resident rights. Corrective action dated 10/13/21 identifies the corrective action to be first written warning. Description of violation identified it to be a failure to comply with standards of customer service. Supervisor's comments identify NA-F will take time to listen to residents, Will confirm with resident that he is moving at a good pace for the resident. Employees comments identify NA-F was shocked by this and feels he had a good interaction with the resident. NA-F understands the importance of good customer service. Coaching provided included reviewing customer service form. Explained all things to patients when turning and repositioning, if something occurs like stepping on a patient's foot, say sorry and tell a nurse so they can assess. Corrective action dated 7/17/22 Incident type includes improper care and failure to follow policy. Documentation of coaching provided included residents need to be moved slowly at	21805		

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21805	Continued From page 39 their ow pace during cares. Resolution includes any further complaints from residents about rushed care or improperly transferring a resident will result in an immediate corrective action or suspension. Corrective action dated 03/20/2024 identified NA-F received a just in time training and education need: "review education on treating each resident individually with dignity. Prior discussion with employee on this issue identified "No". Retraining summery identified staff reviewed the resident bill of rights and dignity policy (attached) including #14 and #15 and #16 in the policy. Comments: Employee verbalized understanding of the policy and the importance of appropriately verbal communication and treating each resident with respect and dignity. Residents bill of rights and dignity policy dated 10/24/2022 identified the purpose of the policy was to reflect current federal and state standards governing "patients' rights". These rights identify specific prerogatives according to the individual while he/she is a resident at this health care facility. To ensure the proper implementation of the resident's bill of rights, the following procedures are followed. #14 The facility must enforce and ensure resident rights are enforced, including the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. #15 the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality. #16 the facility must promote and protect the rights of the resident.	21805		

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21805	Continued From page 40 A returned phone call on 3/27/27 at 10:57 a.m. NA-F recalled having a corrective action regarding the situation. R1 reported to not be aware his voice was that loud and could see why it came across in a different manner. NA-F reported R1 had difficulty with communication and NA-F was trying to understand what she wanted and was unable to understand what she wanted with the pillow positioning due to not knowing R1's needs and preferences. During interview on 3/22/24 at 11:18 a.m., director of nursing (DON) reported there have been various grievances and care concerns reported by FM-A regarding R1's care. DON had received the email by FM-A and had viewed the one from 3/16/24 and did the training with staff on 3/20/24. DON reported NA-F was suspended. When they interviewed NA-F, he did not know what he did wrong. Typically he is a very soft-spoken person and there could be culture barrier. DON reported the facility did not ensure how R1 felt regarding as it could have been traumatic and did not know if it could relate to past trauma. Additionally, the facility had not add added R1's preference to not work with him. DON was unaware what R1's preferences were for the placement and commodes. R13's face sheet identified diagnoses including aphasia following intracranial hemorrhage (difficulty understanding or expressing speech following a brain bleed), morbid (severe) obesity, muscle weakness, and vascular dementia. R13's significant change Minimum Data Set (MDS) dated 1/23/24, R13 required maximal assistance with mobility in bed and was dependent on staff for sitting up, lying down, and	21805		

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21805	Continued From page 41 transfers. R13 was dependent for toileting hygiene. R13's MDS dated 10/12/23, included the last Brief Interview for Mental Status (BIMS) completed, with a score of 3 indicating severe cognitive impairment. R13 care plan dated 09/26/23 identified R13 triggered in ADL's R13 had preferences and other items of need listed in interventions. R13 required staff to assist with eating. Intervention dated 08/18/21 staff are to assist R13 out of bed for meals. Notify nurse if I refuse. Additionally care plan dated 07/06/2021 identified R13 requires staff to help set up supplies and assist with dressing/grooming/hygiene. Level of assistance and preferences are not identified. R13's care plan dated 01/24/24 for communication identified R13 demonstrated unclear speech slurred or mumbled words, speaks very little. Resident will have all needs met with anticipation from staff. Staff are to observe facial expressions and body language and attempt to interpret. Email communication on 03/20/2024 at 7:01 from FM-B to administrator, DON, assistant director of nursing (ADON) and NM-A and NM-B included "Same night gown and socks on since Monday [3/18/24] morning. She should be changed daily into clean night gowns and socks." I was told Monday that the care plan was going to be executed which didn't even last one day. We are truly concerned with the level of care being provided in River Bend as a whole with not only mom but other residents as well. We are hoping this sudden change in care for our mom was not reflective of claim filed justifiably with state as we	21805		

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21805	Continued From page 42 were not the only resident family who filed claims. " During observation of video footage dated 3/20/24, FM-B was in R13's room speaking with the ADON. Video footage shows digital clock time of 11:08 a.m. [due to outside lighting]. During review of video review of conversation with FM-A to ADON. FM-A is expressing the desire for R13 to FM-A expressing R13's preferences related to the care plan being followed. "Consistency, it's all I ask for and for her to get the needs that she needs". FM-A expressed R13's rights and preferences regarding food trays, clothing not being changed and changed back into the same clothing. ADON reported "seems reasonable to me" regarding clothing. ADON reported the plan was to talk with staff. Facility staff failed to address how R13's needs and preferences will be met. Email communication on 3/25/24 at 11:03 from FM-B to administrator, DON, assistant director of nursing (ADON) and NM-A and NM-B included "This morning the aide brought breakfast to mom at 8:25 am and placed it on tray table lateral to mom unopened. Tray table was never placed over bed nor was my mom lifted up to be able to eat. Food sat on tray table until 9:46 am when mom was taken out of bed and changed. At the time, aide placed tray table to my mom opened cold food which was oatmeal without even heating it up. So food sat almost an hour an a half without her being to get to it and was served very cold. " Email communication had a picture of a staff member walking away towards the direction of the room door while R13 was laying in bed with the tray next to R13's bed. During observation of video camera footage from	21805		

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21805	Continued From page 43 3/20/24 at 1:10 p.m., R13 was using a sit to stand EZ-Stand Mechanical lift. Facility staff reported to R13 "don't worry you're not going to fall." When staff asked if R13 was okay she shook her head no, staff did not respond to R13's nonverbal expression. Staff was in viewable position to see R13's nonverbal expressions. During interview on 3/26/24 3:14 with director of nursing (DON), reported that all staff should follow and know how to access up to date care plans. All staff treat residents with dignity and respect in accordance with their residents rights. Facility policy titled resident bill of rights and dignity policy dated 10/24/22 identified the purpose for the resident's bill of rights reflects current federal and state standards governing "patient's rights". These rights identify specific prerogatives according to the individual while he/she is a resident at this health care facility. To ensure the proper implementation of the resident's bill of rights, the following procedures are followed. 1.If resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate information concerning rights/responsibilities in a language familiar to the resident is used. 2.The facility must enforce and ensure resident rights are enforced, including the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 3.The facility must treat each resident with respect and dignity and care for each resident in a manner and in and environment that promotes maintenance or enhancement of his/her quality of	21805		

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21805	Continued From page 44 life, recognizing each resident's individuality. 4.The facility must promote and protect the rights of the resident. 5.The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all residents regardless of payment source. 6.The facility must ensure that the resident can exercise his/her rights without interference, coercion, discrimination, or reprisal from the facility. 7.The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his/her rights and to be supported by the facility in the exercise of his/her rights as required. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on resident rights. The administrator or designee could educate all staff on dignity and respect. The administrator or designee could interview residents routinely to ensure residents feel their dignity and respect are being maintained, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21805		